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	50G007	A. BUILDING _____ B. WING _____	R 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 000}	INITIAL COMMENTS This report is the result of a revisit survey to the 06/10/14 through 06/14/19 Recertification Survey at Lakeland Village. The revisit survey occurred on 08/19/19, 08/20/19, 08/21/19, 08/22/19, 08/23/19, 08/26/19, 08/27/19, 08/28/19, and 08/29/19. A sample of six Clients was selected from a census of 97. Three expanded sample Clients were added. The revisit survey occurred in response to a letter from Lakeland Village alleging they were in compliance with the Conditions of Participation found to be non-compliant from the Recertification Survey. During the revisit, an Immediate Jeopardy was identified on 08/21/19 and the revisit survey was extended into a full survey and all Conditions of Participation were reviewed. Lakeland Village submitted a plan to remove the Immediate Jeopardy on 08/22/19. The Survey Team removed the Immediate Jeopardy on 08/28/19. The revisit survey found repeat and new deficiencies. The facility remained out of compliance.. The survey was conducted by: Gerald Heilinger Jim Tarr Patrice Perry Arika Brasier Justin Smith Olivia St. Claire	{W 000}	POC ON SEPARATE DOCUMENT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

9-26-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 000}	Continued From page 1 The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, ICF/IID Survey and Certification Program PO Box 45600, MS: 45600 Olympia, WA 98504 Telephone: 360-725-3215	{W 000}		
W 102	GOVERNING BODY AND MANAGEMENT CFR(s): 483.410 The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure compliance with the Condition of Participation for Active Treatment for six of six Sample Clients (Clients #1, #2, #3, #4, #5, and #6) and the Condition of Participation for Health Care Services for two of six Sample Clients (Clients #2 and #6) and one Expanded Sample Client (Client #8). This failure resulted in ongoing non-compliance with providing Clients with aggressive training to improve their independence. This failure also resulted in Clients not receiving timely or adequate medical care to meet their health care needs, improve their health, and prevent unnecessary hospitalizations. Findings included ... Observation, record review, and interview showed	W 102		

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W 102	Continued From page 2 six of six Sample Clients did not receive aggressive, continuous active treatment services. This resulted in a failure to meet the Condition of Participation for Active Treatment. See W195 for details. Observation, record review, and interview showed the facility was not in compliance with health care services. This resulted in an Immediate Jeopardy. This resulted in a failure to meet the Condition of Participation for Health Care Services. See W318 for details.	W 102		
{W 104}	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to: 1. Have a process to track when Clients required follow up appointments for specialized medical services. 2. Follow their policy to ensure facility staff completed Client assessments at least 30 days prior to the development of one of six Sample Clients' (Client #6) Individual Habilitation Plan (IHP). 3. Have a policy to ensure staff filed assessments in all Clients' files after	{W 104}		

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{W 104}	Continued From page 3 assessments were completed. These failures resulted in no specialized medical assessment for Client #6, caused inaccurate and incomplete medical records, and prevented the facility from developing accurate IHPs. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... 1. Record review of Client #6's file showed he saw a cardiologist (heart specialist) on 01/11/18. The cardiologist ordered a repeat echocardiogram (a test to determine how well blood flows through the heart) in one year. There was no echocardiogram result for 2019 in the file. During an interview on 08/27/19 at 9:27 AM, Staff E, Registered Nurse (RN), stated that the prior RN tracked follow-up appointments on paper but Staff E used his email calendar to remind him. When asked if there was a facility process to track follow-up appointments, he stated that there was not a facility-wide process. 2. Record review of the facility's policy, "Work Procedure LV [Lakeland Village] 7.1 Individual Habilitation Plan (Annual)," dated 12/28/16, showed staff were to complete their portion of the Comprehensive Functional Assessment between 30 and 90 days prior to the Client's IHP. Record review of Client #6's Speech-Language Assessment, dated 07/15/19, showed an IHP meeting scheduled for 08/07/19, and staff completed the assessment 23 days before the IHP meeting.	{W 104}		

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{W 104}	Continued From page 4 Record review of Client #6's Annual Healthcare Assessment, dated 07/29/19, showed staff completed it 9 days before the IHP meeting. During an interview on 08/28/19 at 11:16 AM, Staff G, Psychology Associate, stated that if they needed information from another discipline and it was not available, they would use an outdated assessment to complete their assessment. 3. Record review of the facility's policy, "Work Procedure LV 7.5 Assessments: IHP," dated 10/18/17, showed that the Clients' annual assessments would be filed when the IHP was implemented, 30-90 days after the assessments were completed. During an interview on 08/28/19 at 11:16 AM, Staff F, Qualified Intellectual Disability Professional (QIDP), stated that the facility policy did not direct staff to file the assessments as they were completed. Staff F stated that the QIDP filed the assessments when they placed the completed IHP in the Client's file, resulting in assessments not available in the Client's chart immediately upon the completion of the assessment.	{W 104}		
W 110	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that includes a separate record for each client.	W 110		

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W 110	Continued From page 5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to define, design, and implement a system to maintain accurate and current Client records for all Clients at the facility. This failure resulted in inaccurate Client files that did not contain necessary information required for staff to work with the Clients in a meaningful way. Findings included ... Record review of facility policy, "LV [Lakeland Village] 6.9 Client Records," dated 04/15/10, showed the policy had no description of whether Client records were designated as hard copy only, digital copy only, or a combination of the two. Current records were in hard copy or digital copy, but not always in both. All staff did not have access to the digital files that might contain necessary information. The policy provided no guidance for adding or removing items from the hard copy file in the cottages. It provided no authorization requirements for staff to use or access Clients' files. The policy provided no schedule of review for Client files to ensure their accuracy or if they were up to date. During an interview on 08/26/19 at 9:00 AM, Staff HH, Forms and Records Analyst 3, stated that the Client Records policy had some discrepancies that made keeping accurate files in the cottages difficult. During an interview on 08/26/19 at 4:05 PM, Staff B, Assistant Superintendent, stated that a Client record was the physical file at the cottage.	W 110		
{W 111}	CLIENT RECORDS CFR(s): 483.410(c)(1)	{W 111}		

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{W 111}	Continued From page 6 The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to file routine assessments and laboratory results in one of six Sample Client's (Client #6) and one Expanded Sample Client's (Client #8) record. This failure resulted in staff not having accurate information in the Client records to use in the development of a comprehensive plan of care. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Client #6 1. Review of Client #6's file on 08/19/19 showed an Individual Habilitation Plan (IHP), dated 08/30/18. The Client had an annual IHP meeting scheduled for 08/07/19 to develop his new IHP. There were no annual assessments for the 2019 IHP in the file. During an interview on 08/19/19 at approximately 10:30 AM with Staff B, Assistant Superintendent, a copy of Client #6's IHP for 2019 was requested. Staff B later provided the 2019 IHP along with the assessments used to for the development of the 2019 IHP. During an interview on 08/28/19 at 11:30 AM,	{W 111}		

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{W 111}	Continued From page 7 Staff F, Qualified Intellectual Disability Professional, stated that they filed the annual assessments when the facility implemented the IHP, 30-90 days after the assessment was completed. 2. Review of Client #6's file showed he saw a cardiologist (heart specialist) on 04/08/19. The file did not contain the full written report of that appointment. During an interview on 08/26/19 at 2:51 PM, Staff L, Medical Services Coordinator, stated that the team lead nurse was responsible for following up to ensure the facility obtained the full report of the appointment. Client #8 Record review of Client #8's file showed a Medication Administration Record, dated 07/2019, which showed a physician ordered an antibiotic for a urinary tract infection. The file did not contain the urine culture results. During an interview on 08/22/19 at 9:27 AM, Staff M, Resource Nurse, stated that there was no specific person assigned to obtain and file a Client's diagnostic test results.	{W 111}		
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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W 124	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one of six Sample Client's (Client #2) guardian was informed of the risks of the recommended interventions or treatments and their right to refuse the treatment or service. This failure resulted in Client #2 receiving medical treatments and interventions without due process. Findings included ... Record review of Client #2's Individual Habilitation Plan, dated 06/26/19, showed he used [redacted] due to lower extremity edema (swelling) during waking hours, an elevated hospital bed, a shower chair, and a high-sided dish for eating. Record review of Client #2's file showed no documentation of a risk versus benefit analysis for these interventions were provided to the guardian and no signed guardian consent for the interventions. During an interview on 08/26/19 at 11:30 AM, Staff P, Qualified Intellectual Disability Professional, stated that she had no documentation of a discussion with Client #2's guardian about the risk versus benefit of the interventions or the right to refuse.	W 124		
{W 125}	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage	{W 125}		

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{W 125}	Continued From page 9 individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to allow one of six Sample Clients (Client #3) and one Expanded Sample Client (Client #7) to exercise their rights. This failure violated Client #3's right to choose his snack, where he wanted to walk, and to have his clothes washed separately from his housemates. This failure violated Client #7's right to privacy when another Client of the opposite sex entered her room whenever he wanted to access his dresser that was kept there. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Communal Laundry Observation on 08/19/19 at 2:20 PM at Pinewood Cottage showed Client #3 put his dirty clothes into a hamper with other Clients' clothes. During an interview on 08/19/19 at 2:30 PM, Direct Care Staff (DCS) stated that the Clients on Pinewood placed their clothes together into a hamper and staff washed their clothes together. Record review of Client #3's Individual Habilitation Plan (IHP), dated 04/25/19, showed it did not contain any information regarding the communal laundry process. During an Interview on 08/20/19 at 10:28 AM,	{W 125}		

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{W 125}	Continued From page 10 Staff U, Attendant Counselor Manager, stated that parents and guardians were not consulted or provided knowledge of the communal laundry process. Snack Observation on 08/20/19 at 9:50 AM at Adult Programs (AP), Room #15, showed an Adult Training Staff (ATS) physically assisted Client #3 to choose his snack on an iPad. Immediately before this, Client #3 independently chose what he wanted to drink on the iPad. Record review of Client #3's IHP, dated 04/25/19, showed he had the ability to choose his own food. During an interview on 08/21/19 at 9:00 AM, Staff V, Qualified Intellectual Disability Professional (QIDP), stated that Client #3 should be allowed to choose his own snack or refuse it. Directed where to walk Observation on 08/20/19 at 10:04 AM at AP showed Client #3 attempted to walk towards his cottage after work. The ATS staff had Client #3 grasp her arm and she steered him to walk in the opposite direction from his cottage. She walked him to the end of campus and then back to his cottage. Record review of Client #3's IHP, dated 04/25/19, showed Client #3 did not require any assistance with walking. During an interview on 08/21/19 at 9:00 AM, Staff V, QIDP, stated that DCS should not assist Client #3 to walk or direct him where to walk.	{W 125}		

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{W 125}	Continued From page 11 Dresser Observation on 08/19/19 at 1:55 PM at Pinewood Cottage showed Client #3 (male) had a dresser in Client #7's (female) bedroom. Record review of Client #3's IHP, dated 04/25/19, showed no mention of the dresser. During an interview on 08/21/19 at 9:00 AM, Staff V, QIDP, stated that he did not recognize the privacy and rights issues in relation to Client #3 keeping a dresser in Client #7's bedroom.	{W 125}		
W 126	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure one of six Sample Clients (Client #2) had a formal money management program based on an identified need in his Direct Care Independent Living Skills Assessment. This failure resulted in no training for Client #2 on how to be more independent in handling his money. Findings included ... Record review of Client #2's Direct Care Independent Living Skills Assessment, dated 05/15/19, showed Client #2 needed more training to be self-reliant in money management for the	W 126		

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W 126	Continued From page 12 following categories: matching and identifying bills and coins; finding the appropriate combination of change for items; counting to 25; using a vending machine; making purchases, keeping money safe; budgeting; and deposit and withdrawal of funds. Record review of Client #2's Individual Habilitation Plan, dated 06/26/19, showed he did not have an objective or training plan for money management. During an interview on 08/26/19 at 1:30 PM, Staff P, Qualified Intellectual Disability Professional, stated that Client #2 was not fully independent in money management and did not have a money management program.	W 126		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to investigate two documented instances of bruising for one of six Sample Clients (Client #6). This failure prevented the facility from identifying the source of the bruises, developing a plan to prevent recurrence, and placed the Client at risk for abuse. Findings included ...	W 153		

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W 153	Continued From page 13 Record review of Client #6's Interdisciplinary Progress Notes, dated 07/08/19, contained an entry that showed, "Discoloration Purple/Blue around nipples from pinching area ..." There was no documentation regarding an investigation, prevention plan, or monitoring of the identified bruising. Record review of Client #6's Annual Healthcare Assessment, dated 07/29/19, showed bruising around both of the Client's nipples. There was no description of the bruises, identification of the potential cause, a plan to monitor them, or a plan to prevent recurrence. During an interview on 08/27/19 at 2:08 PM, Staff H, Advanced Registered Nurse Practitioner (ARNP), stated that when they completed the annual assessment they did not include a description of the bruising. Staff H stated that there were four purple finger marks by each nipple and staff told the ARNP that the bruises were a result of the Client "stimulating" himself. During an interview on 08/27/19 at 11:16 AM, Staff D, Developmental Disabilities Administrator I, stated that the facility should have investigated the two instances of bruising around Client #6's nipples to determine the cause of the injuries.	W 153		
{W 159}	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Qualified	{W 159}		

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{W 159}	Continued From page 14 Intellectual Disability Professionals (QIDPs) provided rigorous oversight of six of six Sample Clients' (Clients #1, #2, #3, #4, #5, and #6) treatment and training which would ensure Clients' needs were met, active treatment occurred, and health care needs were met. This failure prevented Clients from having their training needs met, resulted in a longer stay at the facility than necessary, and did not ensure consistent, accurate health information was available to all areas and put Clients' health at risk. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Client #1 Record review of Client #1's file showed a section where staff could access Client #1's Individual Habilitation Plan (IHP). In this section was a Lakeland Village Individual Habilitation Plan/Discharge Plan with a handwritten note, "Updated 8/5/19." This document only had pages numbered 1, 2, 3, 4, 15, 16, 19, 20 and 21. There was a second IHP with a handwritten note, "Updated 4/19/2019" that only had pages 1, 2, 3, 4, 5, 10, 12, 15 and 16. There was a third IHP, dated 02/21/19, that was 22 pages long. A Direct Care Staff (DCS) had to read all three versions of the IHP to understand how to provide care and active treatment for Client #1. During an interview on 08/19/19 at 12:37 PM, Staff C, Quality Assurance Director (QAD), stated that he was aware that some Clients' files only had the IHP updates placed in them rather than the whole document. He stated DCS would utilize	{W 159}		

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{W 159}	Continued From page 15 the top document to learn about the Client. During an interview on 08/27/19 at 10:59 AM, Staff D, Developmental Disabilities Administrator 1 (DDA1), Staff R, QIDP, and Staff S, Psychology Associate, stated that just the IHP updates were put in the file per the instructions of Staff C, QAD. Staff D stated she heard there was some confusion over just putting the updates in the Clients' files and they could have put in the whole document. Client #2 Activities of Daily Living (ADLs) Record review of Client #2's Direct Care Independent Living Skills Assessment, dated 05/15/19, showed recommendations for training to increase independence with ADLs in the following areas: personal hygiene, grooming, dental hygiene, and dressing. Record review of Client #2's Occupational Therapy Annual Assessment, dated 05/24/19, showed recommendations to continue to train to increase independence with ADLs. Record review of Client #2's IHP, dated 06/26/19, showed no training objective for personal hygiene, grooming, dental hygiene, and dressing. During an interview on 08/26/19 at 1:30 PM, Staff P, QIDP, stated that Client #2's primary need was to achieve mental health stability to support participation in daily living activities. When asked if she felt Client #2 had enough training objectives for ADLs, she acknowledged he could have more and that she needed to update his IHP.	{W 159}		

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{W 159}	Continued From page 16 Banana Program Record review of Client #2's training program D. 05 to slice a banana, showed the materials to be used were a banana slicer and a peeled banana. It showed the frequency to run the program was on each shift, whenever Client #2 chose to eat a banana. Record review of Client #2's Monthly Program Recording Form for his banana slicing program for July 2019 showed twenty one opportunities that the program was not run because there were no bananas available. Record review of Client #2's Monthly Program Recording Form for his banana slicing program for 08/01/19 through 08/18/19 showed seven opportunities that the program was not run because there were no bananas available. During an interview on 08/26/19 at 1:30 PM, Staff P, stated that staff could not run the program without bananas available and that the program was problematic. Money Management Record review of Client #2's IHP, dated 06/26/19, showed he was not independent in money management. It did not show a formal training objective for money management. Record review of Client #2's Direct Care Independent Living Skills Assessment, dated 05/15/19, showed he was capable of being independent in: identifying numbers and money from non-money; understood the value of money;	{W 159}		

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{W 159}	Continued From page 17 and understood exchanging money. He was not independent in: matching coins; matching bills; identifying coins or bills; finding the appropriate combination of money; counting to 25; using a vending machine; making purchases in a store; keeping his money safely on his person; budgeting money; and depositing or withdrawing money. During an interview on 08/26/19 at 1:30 PM, Staff P stated that there was no formal money management program for Client #2. Client #3 Observation on 08/20/19 at 10:04 AM showed Client #3 walked around campus. Client #3 walked with his right foot pointing to the right while slightly dragging his right foot. Record Review of Client #3's IHP, dated 04/25/19, showed foot orthotics (an assistive device to aid with walking) as adaptive equipment. Record review of Client #3's Requested Evaluation, dated 04/30/19, to have his orthotics fitted to his favorite shoes showed the foot orthotics could not be fitted into the favorite shoes. During an interview on 08/21/19 at 9:00 AM, Staff V, QIDP, stated that he was not aware Client #3 was not wearing the orthotics. Client #4 Incorrect tracking	{W 159}		

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{W 159}	Continued From page 18 Record review of Client #4's Target Behavior Logs (TBLs) from 06/02/19 through 08/09/19 showed they used one code number, 22B, to track three distinct behaviors: intentional incontinence (urinating or having a bowel movement somewhere other than the toilet); stripping (taking one's clothes off in front of others without permission); and emesis (vomiting). Further record review of the TBLs showed they contained the statement at the bottom, "Please use back of log to make additional comments." Fourteen of the 20 TBLs reviewed had no comments on the back of the form. During an interview on 08/27/19 at 11:31 AM, Staff P, QIDP, stated that the person responsible for that program was on vacation. When asked, Staff D, DDA1, Staff P, and Staff Q, Attendant Counselor Manager, stated that while an explanation on the back would be helpful, one code to track three different behaviors was confusing. Lack of oversight for programs Record review of a Functional Assessment and Positive Behavior Support Plan (PBSP), dated 02/06/19, for Client #4 showed: a. a replacement behavior to learn to utilize her iPad to communicate her basic needs and wants to others. There was no program for teaching this behavior. b. a short-term objective: "Reduce episodes	{W 159}		

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{W 159}	Continued From page 19 [sic] inappropriate social interpersonal behavior (to communicate her needs) to less than average 20 times per month by June 2019." The Program Description Form for this objective was blank with a hand written note to see the PBSP. The PBSP instructions provided directions to manage her behavior but did not show staff how to teach her to reduce the behavior episodes. c. a short-term objective: "Increase use of [Client #4's first name] iPad to communicate her needs at least 3 times per day by June of 2019." There was no program for teaching this behavior. Record review on 08/19/19 of Client #4's IHP, dated 03/06/19, revealed a Non-Program Service 09 that indicated programs were being developed to teach Client #4 to use the iPad independently. Review of the file showed there was only one program for use of the iPad. During an interview on 08/27/19 at 11:31 AM, Staff P stated that they were still working on developing programs for Client #4 to use her iPad and was unable to produce a teaching plan for the short-term objective to increase iPad use to three times per day. During an interview on 08/27/19 at 11:31 AM, Staff D, Staff P, and Staff Q, stated that Client #4 did not have enough programs to train her on the use of the iPad to communicate. When reminded Client #4 had the iPad since at least February 2019, six months, and asked if there should be more programs for this length of time, Staff Q stated that he has not written more programs as they are working on getting Client #4 comfortable using the iPad. There was no program for this.	{W 159}		

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{W 159}	Continued From page 20 Unreconciled discrepancies 1. Record review of a chronic (ongoing) Nursing Plan of Care, dated 05/14/19, showed foraging for food in the Nursing Diagnosis/Problem Statement as a behavior to decrease. Record review of the IHP, dated 03/06/19, for Client #4 had a section titled, "Nursing Care Plan" that showed Client #4 stole food if the opportunity occurred. Record review of a Lakeland Village Functional Assessment, dated 02/19/19, showed foraging for food was no longer in her PBSP as she had not engaged in this behavior since 2017. During an interview on 08/27/19 at 11:31 AM, Staff P stated that Client #4 "graduated" her program for foraging for food in 2017 and she no longer did this behavior. However, Staff Q stated that Client #4 still tries to forage for food and the staff redirect her. Staff P stated that she was unaware of this. 2. Record review of a Lakeland Village Functional Assessment, dated 02/19/19, showed aggression as a target behavior that occurred at a very low frequency. It also showed several episodes occurred in one day. During an interview on 08/27/19 at 11:31 AM, Staff P was asked if several episodes of aggression in one day was a very low amount. Staff P stated that it was not. 3. Record review of a second IHP-Addendum, dated 03/06/19, for Client #4 showed her primary	{W 159}		

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{W 159}	Continued From page 21 need was, "Increase augmentative [alternative] communication methods to promote greater independence." Review of Client #4's teaching plans all showed the primary need as, "Increase augmentative communication methods to promote greater independence." During an interview on 08/27/19 at 11:31 AM, Staff P stated that Client #4's primary need was to increase augmentative communication methods. When asked how objectives to put money in her money pouch, pick up a medication blister pack, wipe her chin, turn on the tub water, and walk around outside related to increasing communication, Staff P stated that it all relates to communication but could not describe how. Lack of programs Record review of Client #4's IHP-Addendum, dated 03/06/19, showed the following programs and schedule of implementation for each: Wipe her chin during meals. At all meals and snacks. Use picture cards to choose an activity. Natural occurring opportunities. Put money in her money pouch. At least three times a week. Turn on the tub water. Once daily at bath time. Walk around the Evergreen courtyard sidewalk loop. Daily on shifts 1 & 2. Use iPad to choose a drink from two choices. Monday - Friday, at AP, once per session. Pick up the medication blister pack. Twice	{W 159}		

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{W 159}	Continued From page 22 daily at medication pass. Reduce episodes of inappropriate social interpersonal behavior. No frequency indicated on the teaching plan. During an interview on 08/27/19 at 11:31 AM, Staff D, Staff P, and Staff Q stated that the implementation of these programs would not occupy most of Client #4's day. Client #5 1. Record review of Client #5's IHP Addendum, dated 08/19/19, showed: a. he had a primary need to increase cooperation with training tasks. There was no program to address this need. b. showed he had eight training programs and they were to be implemented in isolated, specific situations which left the majority of his day without specific programs or directions for training on how to meet his needs. 2. Record review of Client #5's training programs for Objective L.23 and Objective A.48 showed: a. the criteria for success and being able to move on to additional training was "80% for 4 Weeks." 3. Record review of Client #5's: a. IHP, dated 05/22/19, showed he had a left side hemiparesis (weakness of the side of the body) b. assessments showed: (1.) the Communication Assessment, dated 08/08/19, did not identify Client #5 needed training on specific skills. (2.) the Occupational Therapy Assessment, dated 04/22/19, did not identify	{W 159}		

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{W 159}	Continued From page 23 Client #5 needed training on specific skills. (3.) the Physical Therapy Assessment, dated 04/19/19, did not identify Client #5 needed training on specific skills. (4.) the Adult Training Programs Assessment, dated 04/09/19, assessed his activities in the "Plant Room," but did not assess his vocational skill strengths and weaknesses. During interviews on 08/21/19 at approximately 9:30 AM, on 08/28/19 at 11:23 AM, and on 08/29/19 at 3:30 PM, Staff Z, QIDP, stated that Client #5's objectives did not take up a significant portion of his day, the facility had other options to choose from for time frames for success on objectives, there was not a specific program to address his need for increased cooperation, and that assessments for Client #5 did not give many training objective recommendations. During an interview on 08/21/19, Staff K, Adult Programs Supervisor, stated that they did not do vocational assessments at the facility. Client #6 - Record review of Client #6's Active Treatment Schedule (ATS) at Adult Programs (AP), Room 5, dated 08/08/19, listed an allergy to all nuts, except peanuts. Record review of Client #6's Annual Nursing Healthcare Review, dated 06/12/19, showed a food allergy panel from 03/16/17 that identified he had no allergy to cashews, peanuts, or walnuts. The facility removed the food allergy from Client #6's diet because of the testing. Record review of Client #6's Annual Healthcare Assessment, dated 07/29/19, showed no allergies	{W 159}		

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{W 159}	Continued From page 24 to foods. During an interview on 08/27/19 at 2:50 PM, Staff F, QIDP, stated that she did not know what information was on the ATS at AP. When asked if there would be concern for the communication of potential food allergies to outside services, Staff F stated that she had never had a Client go to school off campus so it would not be a concern.	{W 159}		
W 166	PROFESSIONAL PROGRAM SERVICES CFR(s): 483.430(b)(1) Professional program staff must work with paraprofessional, nonprofessional and other professional program staff who work with clients. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that the physical therapist trained staff on how to position one of six Sample Clients (Client #2) in a modified wheelchair with a padded armrest to improve his posture, nor did the physical therapist monitor the modifications to ensure they were effective. This failure resulted in Client #2 sitting in his wheelchair in a manner that could negatively impact his mobility, cause complications with his suprapubic catheter (a device inserted into the bladder to drain urine if one can't urinate on their own), and caused pain and discomfort. Findings included ... Record review of a Physical Therapy Requested Evaluation for Client #2, dated 01/02/19, showed a recommendation for a padded right armrest to	W 166		

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W 166	Continued From page 25 be added to his wheelchair. Record review of Client #2's Physical Therapy Annual Assessment, dated 05/08/19, showed, "that from previous assessments [Client #2's first name] has mild right thoracic [small spinal curve to the right] and left lumber scoliosis [a curvature of the spine] with the right shoulder higher than the left." It gave recommendations for staff to encourage Client #2 to increase his upright posture. Record review of Client #2's medical file showed he had outpatient surgery on 07/01/19 to have a suprapubic catheter placed due to frequent urinary infections. Observation on 08/20/19 at 86 Cascade Cottage from 8:20 AM to 9:03 AM showed Client #2's head fell towards his right shoulder with his posture leaned forward with his head down towards his knees three times. Direct Care Staff (DCS) working with him encouraged him to lift his head up. Observation on 08/28/19 at 86 Cascade Cottage from 9:45 AM to 11:10 AM showed Client #2 sat in his wheelchair, leaning forward and to the right with his head towards his knees. Client #2's right arm was not on the built up pad attached to the right side of his chair. During an interview on 08/28/19 at 11:00 AM at 86 Cascade Cottage, the DCS who worked with Client #2 explained that the padding on Client #2's wheelchair was repositioned often because it slipped or Client #2 pulled on it. He stated Client #2 sometimes leaned very far forward and they had to keep him buckled into his wheelchair or he	W 166		

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W 166	Continued From page 26 would fall out. When asked if there was a process for documenting or reporting concerns about Client #2's posture, the DCS stated that there was no specific process, but they could alert the Attendant Counselor Manager or the nurse who could then contact the Physical Therapist. During an interview on 08/28/19 at 11:25 AM, Staff AA, Physical Therapist, and Staff KK, Physical Therapist Assistant, stated that Client #2's wheelchair was modified with the padded arm rest at the beginning of January. Staff KK explained that follow up to ensure equipment worked correctly and assisted the Client usually occurred soon afterward and that quarterly reviews also occurred. They could not provide any documentation that follow up, staff training, or review occurred.	W 166		
W 185	FACILITY STAFFING CFR(s): 483.430(c)(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure Direct Care Staff (DCS) were not required to perform duties that took them away from Client care responsibilities for four of eleven cottages (72/73 Pinewood, 82/83 Sunrise, 70/71 Evergreen, and 94/95 Bigfoot). This failure resulted in a lack of care and learning time for the Clients in those cottages.	W 185		

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W 185	Continued From page 27 Findings included ... Pinewood Cottage Record review of Pinewood Cottage's Shift 2 Daily Assignment Sheet showed each of the four post assignments (designations of which Clients each staff provided care/training for) included assigned support services' duties for DCS to complete (i.e. laundry, mopping, garbage, and linen). During an interview on 08/20/19 at 10:28 AM, Staff U, Attendant Counselor Manager (ACM), stated that DCS were assigned these duties per the instructions on the assignment sheet along with the care and training of Clients. 82/83 Sunrise Cottage Record review of 82/83 Sunrise Cottage's Shift 1 Post Schedules for groups 1, 2, 3, 4, 5 and 6 showed a disclaimer at the end of each of them that read, "cleaning responsibilities on weekends and on days we have no housekeeping services." The cleaning duties for each post assignment were then laid out in detail. During an interview on 08/20/19 at 2:45 PM, Staff X, DCS, and Staff Y, DCS, stated that DCS were responsible for support services as an assigned duty for their post along with the care and training of Clients. Bigfoot Cottage Record review of Shift 1 and Shift 2 Post Assignments for Bigfoot Cottage showed each DCS was assigned housekeeping duties in	W 185		

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W 185	Continued From page 28 addition to their responsibilities with Clients. During an interview on 08/21/19 at 10:10 AM, Staff MM, ACM, stated that the Post Assignment sheets for Bigfoot Cottage were current and accurate. Evergreen Cottage Record review of Shift 1 Post Assignments for Evergreen Cottage showed four of the five DCS were assigned housekeeping duties in addition to their responsibilities with Clients.	W 185		
{W 195}	ACTIVE TREATMENT SERVICES CFR(s): 483.440 The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure their systems provided all Clients with treatment and training that aggressively met needs and allowed Clients to learn skills quickly. The facility failed to ensure Qualified Intellectual Disability Professionals (QIDP) completed their job in a manner which promoted Clients having the best opportunity to have their needs met and learn skills to become more independent. These failures prevented Clients from living in a less restrictive living setting. This is a repeat citation from the Recertification Survey on 06/14/19.	{W 195}		

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{W 195}	Continued From page 29 Findings included ... 1. Through observation, record review, and interview, it was determined facility QIDPs did not develop Individual Habilitation Plans (IHP) which met all of the Clients' needs and provided for training throughout the majority of the Clients' day. QIDPs set success criteria for training programs which were extended in time and were not based on the Client's learning rate. QIDPs did not ensure that "primary needs" identified on the IHPs had specific training programs to meet the need. QIDPs were not aware of program requirements and were not ensuring the correct type of data was part of the program or an accurate analysis of progress was being made for each program. QIDPs did not ensure all Clients had training in required basic care needs. See W159, W196, W206, W227, W230, W234, and W236 for additional details. 2. Through observation, record review, and interview, it was determined Sample Clients #1 - #6 did not have aggressive active treatment when their IHPs did not meet all of their needs and training was not provided during a majority of their day. See W196, W206, W227, and W242 for details. 3. Through record review and interview, it was determined Sample Clients #3 and #5 had IHPs that did not meet each of the Clients' needs. See W206 for details. 4. Through observation, record review, and interview, it was determined Sample Client #6 had a need that had not been identified and assessed by the facility and did not have a thorough assessment of his ability to	{W 195}		

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{W 195}	Continued From page 30 communicate. Client #3 did not have an assessment for an assistive device. See W214, W218, and W220 for details. 5. Through observation, record review, and interview, it was determined Sample Clients #1, #3, #5, and #6 did not have training objectives in their IHPs for identified needs. See W227 for details. 6. Through record review and interview, it was determined Sample Clients #4 and #6 had training objectives with success criteria that were not individualized according to the Clients' assessed rates of learning. See W230 for details. 7. Through observation, record review, and interview, it was determined Sample Client #6 had training programs that did not provide clear instructions to staff on how to implement the programs. See W234 for details. 8. Through record review and interview, it was determined Sample Clients #1, #2, #3, and #4 had needs in the basic skill areas for independent living but did not have training programs in their IHPs. See W242 for details. 9. Through observation, record review and interview, it was determined the facility did not encourage Sample Clients #1 and #3 and Expanded Sample Client #9 the opportunity do things for themselves and encourage them to make choices. See W247 for details. 10. Through observation, record review, and interview, it was determined Sample Clients #3 and #6 had training programs that were implemented incorrectly by staff. See W251 for	{W 195}		

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{W 195}	Continued From page 31 details.	{W 195}		
{W 196}	ACTIVE TREATMENT CFR(s): 483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide continuous, aggressive treatment and training for six of six Sample Clients (Client #1, #2, #3, #4, #5, and #6) when they did not provide training throughout the day on identified needs, and did not have programs for identified primary needs. This failure prevented Clients from having the opportunity to learn skills to increase their independence. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Client #1 Review of Client #1's Individual Habilitation Plan (IHP) Addendum, updated 08/05/19, showed a	{W 196}		

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{W 196}	Continued From page 32 primary need to stabilize his behavioral and chronic illnesses to be able to maintain his Activities of Daily Living (ADLs). The IHP also identified needs for Daily Self Help Skills and the use of special training consideration for moderate to severe hearing loss. Client #1's IHP-Addendum showed the only formal training programs were for money management, identifying why he took a medication, an adult program to load a delivery cart, two behavioral programs to control aggression, and to maintain his deep breathing technique. There were no formal training plans to maintain his ADLs or to stabilize his chronic illnesses. Observation on 08/20/19 from 8:21 AM to 9:37 AM at Hillside Cottage showed Client #1 rinsed and put his dishes in a rack at Direct Care Staff's (DCS) request. Staff assisted Client #1 to put on his wrist watch, put on his elbow and knee pads, and assisted him to brush his teeth and comb his hair. Client #1 refused when a staff asked him to help some more with dishes. Another staff got Client #1 a glass of water and a rag. There was no formal training during this observation. Observation on 08/20/19 at 10:26 AM at Hillside Cottage showed Client #1 had returned from the medical clinic. At 10:40 AM, Client #1 started to ride his bike independently around the lower campus. Observation on 08/21/19 from 9:24 AM to 10:20 AM at Hillside Cottage showed Client #1 sat outside the front entrance with his bike. He came inside the cottage, talked to staff, and then went and sat in the Attendant Counselor Manager's (ACM) office a couple of times. He talked to staff	{W 196}		

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{W 196}	Continued From page 33 in the kitchen area and then went outside to look at his bike. Staff W, ACM, walked with Client #1 to the main building and they entered an activity room where Client #1 watched the Dukes of Hazzard on a computer monitor. There was no formal training during this observation. During an interview on 08/21/10 at 1:27 PM, Staff W stated that new programs were being developed but had not been started yet. He stated that Client #1's primary needs were medical and behavioral and he was difficult to engage in training. Observation on 08/27/19 from 7:07 AM to 8:15 AM showed Client #1 prepared his breakfast. A DCS verbally cued him through making toast and dishing up scrambled eggs. The DCS staff provided physical assistance when they opened the bread bag, brought Client #1 a container of butter, opened the container of scrambled eggs, and closed and put away the container of Nutri-grain bars. An Adult Training Staff helped Client #1 cut up his egg sandwich. There was no formal training during the meal. During an interview on 08/27/19 at 10:59 AM, when asked about the few number of training programs in Client #1's IHP, Staff D, Developmental Disabilities Administrator 1 (DDA1), Staff R, Qualified Intellectual Disability Professional (QIDP), and Staff S, Psychology Associate, stated that they had discontinued some training programs for Client #1 and new ones were being developed, but were not implemented prior to the start of the survey. They stated that they believed that Client #1's resistance to training and his aggression may be the result of seizures. They also stated that staff	{W 196}		

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{W 196}	Continued From page 34 should not be doing things for Client #1 because he is capable of doing them for himself. Client #2 Record review of Client #2's IHP, dated 06/26/19, showed his primary need was to achieve mental stability to support participation in daily living activities in his home and work environments. It did not show a program that addressed this need. It listed six active formal training programs: 1. making crystal light which was run during meal times 2. slicing a banana which was run during snack or meal times 3. retrieving a washcloth from a shower caddy which was run while bathing 4. choosing a comfort item in lieu of a cigarette which was run if he requested a cigarette outside his normal smoke time 5. bringing his iPad to the work table which was run at Adult Programming 6. pulling up his pant leg to empty his urinary drainage bag which was run during med administration time During an interview on 08/26/19 at 1:30 PM, when asked about a program for his mental stability, Staff P, QIDP, stated that Client #2's program for choosing a comfort item when he wanted a cigarette was appropriate to address this. Client #3 Record review of Client #3's IHP, dated 04/25/19, showed Client #3 had primary needs in alternate communication systems, being involved in	{W 196}		

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{W 196}	Continued From page 35 functional activities, and avoiding challenging behavior. Client #3 had custom orthotics (an assistive device to aid with walking) prescribed by an orthopedic specialist. Record review of Client #3's IHP, dated 08/13/19, showed strengths in initiating and completing self-help and daily living skills. It showed Client #3's refusals to participate got in the way of learning new skills in multiple areas. Record review of Client #3's IHP, dated 04/25/19, showed no programs to address Client #3's constant refusal to participate in training and using an alternate communication system. The IHP did not have a program for how Client #3 would learn to wear his orthotics. During an interview on 08/21/19 at 9:00 AM, Staff V, QIDP, stated that Client #3's current IHP did not contain plans or instructions to address his refusals, communication with alternate devices, or to use his orthotics. Client #4 Observation on 08/26/19 at Evergreen Cottage from 10:52 AM - 12:11 PM showed Client #4 put some clothes items into the laundry room and used the bathroom. Staff Q, ACM, helped her put on a jacket. A DCS asked her to help with setting up for lunch, which she did. Client #4 finished lunch at 12:11 PM. There was no formal training during this time, except to wipe her chin. Observation on 08/26/19 at Evergreen Cottage from 2:33 PM - 3:17 PM showed Client #4 sat on a recliner in the living room with a blanket over her legs. She went into the bathroom and a DCS	{W 196}		

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{W 196}	Continued From page 36 wet, dried, and brushed her hair, then put her shoes on her. The DCS then directed Client #4 to the dining room table and brought her coffee, milk, her drinking cup, bowl, large spoon, her small eating spoon, and cottage cheese. The DCS put a clothing protector on her, and she ate a snack. After the snack, she left the cottage with the DCS for an activity. No communication picture cards were shown to Client #4 to choose an activity from during this observation. There was no formal training during this time, except to wipe her chin. Observation on 08/26/19 at the art room from 3:27 PM - 3:56 PM showed Client #4 sat at a table with a canvas, paintbrush, and paint. The facilitator showed her how to use brushes and sponges and poured her paint. Upon exiting the art room, the DCS told Client #4 she could rest when they got home. No programs were observed to be implemented during this time. Record review of Client #4's IHP-Addendum, dated 03/06/19, showed the following programs and schedule of implementation for each: Wipe her chin during meals. At all meals and snacks. Use picture cards to choose an activity. Natural occurring opportunities. Put money in her money pouch. At least three times a week. Turn on the tub water. Once daily at bath time. Walk around the Evergreen courtyard sidewalk loop. Daily on shifts 1 & 2. Use iPad to choose a drink from two choices. Monday - Friday, at AP, once per session. Pick up the medication blister pack. Twice daily at medication pass.	{W 196}		

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{W 196}	Continued From page 37 During an interview on 08/27/19 at 11:31 AM, Staff D, DDA 1, Staff P, QIDP, and Staff Q, ACM, stated that the implementation of these programs would not occupy most of Client #4's day and this was not aggressive. Client #5 1. Record review of Client #5's IHP Addendum, dated 08/19/19, showed: a. he had a primary need to increase cooperation with training tasks. There was no training program to address this need. b. showed he had eight training programs: grab a paper towel; pull a privacy curtain closed; put his dishes/utensils in a basket; push a communication button; water a pot; take a medication cup to the sink; put a money container in a drawer; and put an activity item away. These programs were implemented in isolated, specific situations which left the majority of his day without specific directions on how to meet his needs. During interviews on 08/21/19 at approximately 9:30 AM and on 08/28/19 at 11:23 AM, Staff Z, QIDP, stated that Client #5's objectives did not take up a significant portion of his day, and there was not a specific program to address his need for increased cooperation. Client #6 Observation at Adult Programs (AP), Room 3, on 08/19/19 from 1:24 PM-1:59 PM showed staff instructed Client #6 to smash aluminum cans with	{W 196}		

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{W 196}	Continued From page 38 an electric machine and put gloves on his hands. Client #6 complied with staff directions and sat idly when staff were working with other Clients. No training was observed during the observation. Observation at AP, Room 5, on 08/19/19 from 2:01 PM-2:24 PM showed staff instructed Client #6 to wash his hands, throw a cup in the garbage, and put snack items away in the refrigerator. Client #6 complied with staff directions on all occasions. No training was observed during the observation. Observation at AP, Room 3, on 08/19/19 from 2:24 PM-2:50 PM showed staff instructed Client #6 to put cardboard boxes in a compacter, smash aluminum cans with an electric machine, and move a cart filled with cardboard. Client #6 complied with staff directions but did not initiate any activities unless staff told him. No training was observed during the observation. Observation at Apple Cottage on 08/20/19 from 8:21 AM-9:30 AM showed staff asked Client #6 to take a pitcher of juice into the kitchen. Client #6 did not respond. A different staff stated, "Go put that in the fridge." and Client #6 complied with the instruction. Staff then instructed Client #6 to get a washcloth wet and wipe the table off. Client #6 complied. From 9:02 AM-9:19 AM, Client #6 sat on his bed. From 9:19-9:29 AM Client #6 sat at the kitchen table with a drum in front of him, occasionally tapping on the drum. Client #6 left the cottage at 9:30 AM, no training was observed during the observation. Observation at Apple Cottage on 08/21/19 from 7:18 AM-7:54 AM showed staff instructed Client	{W 196}		

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{W 196}	Continued From page 39 #6 to wash his hands, get his dishes from the kitchen, get 2 pitchers of drinks from the kitchen, serve hash browns on to his plate, and dish up a biscuit with staff assistance. Client #6 complied with staff instructions. No training was observed during the observation. Observation at Apple Cottage on 08/26/19 from 11:21 AM-11:56 AM showed staff instructed Client #6 to take dishes containing macaroni and cheese, cake, and canned apricots to the table. Client #6 complied with staff directions. Client #6 served himself three spoons full of macaroni and cheese, served himself some peas, and served himself a piece of cake. Client #6 complied with all directions from staff, he did not initiate any activity without staff direction. No training was observed during the observation. Record review of Client #6's IHP, dated 08/30/19, showed Client #6 had a primary need to increase his attention to tasks with less cues from staff. The IHP listed the following long range goals; increase dental hygiene skills, increase his ability to eat independently, increase his ability to complete grooming, increase his vocational skills, increase his ability to take his medication independently, and increase his money management skills. There was no program to help him become less cue dependent on staff. During an interview on 08/27/19 at 2:50 PM, Staff F, QIDP, stated that Client #6 depended on staff cues to complete all of his routine tasks. When asked how the current training plans increased Client #6's independence, Staff F stated that the Client would require less cues over time. Staff F stated that Client #6 did not have training specific	{W 196}		

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{W 196}	Continued From page 40 to becoming less dependent on staff cues.	{W 196}		
{W 206}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to: (i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and (ii) Designing programs that meet the client's needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an Individual Habilitation Plan (IHP) that addressed the identified needs, and contained training plans related to those needs, for two of six Sample Clients (Clients #3 and #5). This failure prevented the Clients from having the opportunity to learn skills to increase their independence and move to a community living setting. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Client #3 Record review of Client #3's Functional Assessment (FA), dated 03/04/19, and IHP, dated	{W 206}		

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{W 206}	Continued From page 41 04/25/19, showed his primary need was related to refusing to participate in training. Client #3's FA and IHP also showed he needed training in an alternative communication system. Record review of Client #3's Positive Behavior Support Plan (PBSP), dated 03/04/19, showed he grasped people's arms to gain their attention and as a form of aggression. Record review of Client #3's IHP showed he had no programs to address his refusal to participate in training nor his lack of communication skills. Record Review of Client #3's IHP and PBSP showed he did not have a program to address grasping people's arms nor how staff should respond on those occasions. During an interview on 08/21/19 at 9:00 AM, Staff V, Qualified Intellectual Disability Professional (QIDP), stated that his IHP currently did not have training programs for refusing training or using an alternative communication system. Client #5 Record review of Client #5's IHP Addendum, dated 08/19/19, showed he had a primary need to increase cooperation with training tasks. There was no program to address this need in the IHP. During an interview on 08/28/19 at 11:23 AM, Staff Z, QIDP, stated that Client #5 did not have a specific program to address his need for increased cooperation.	{W 206}		
{W 214}	INDIVIDUAL PROGRAM PLAN	{W 214}		

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{W 214}	Continued From page 42 CFR(s): 483.440(c)(3)(iii) The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to identify and address behavioral needs for one of six Sample Clients (Client #6). This failure resulted in no training for Client #6 to reduce self-injurious behaviors (SIB) or teach him how to communicate what was distressing him. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Observation at Apple Cottage on 08/20/19 at 8:28 AM showed Client #6 sat at the dining room table rocking and slapping the right side of his stomach. Direct Care Staff told the Client they were getting him a PRN (as needed medication). Observation at Apple Cottage on 08/20/19 from 9:19 AM-9:29 AM showed Client #6 hit his stomach, despite multiple cues from staff to hit a drum that was on the table in front of him. The Client did not receive a PRN medication. Record review of Client #6's Annual Nursing Healthcare Review, dated 06/12/19, identified his SIB as hitting, biting, or scratching himself. It did not identify what need the Client met when he exhibited those behaviors.	{W 214}		

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{W 214}	Continued From page 43 Record review of Client #6's Psychological Assessment, dated 07/01/19, showed a history of jumping up and down, yelling, hitting himself on the head, legs, stomach and chest, and biting his hand. The facility discontinued a Positive Behavior Support Plan (PBSP) in 2018, as the behaviors were "less intense and less frequent..." The assessment did not describe what need the Client met when he exhibited those behaviors. Record review of Client #6's Comprehensive Functional Assessment of Adult Training Programs, dated 07/03/19, showed, "His SIB increases when he is agitated and increases in force." It recommended the Client decrease SIB and gain communication skills prior to considering community employment. It did not describe what SIB the Client exhibited or what need the Client met when he exhibited SIB. Record review of Client #6's Mental Wellness Support Strategies, dated 07/03/19, showed the facility determined the Client did not require a PBSP related to his mental health treatment plan. It listed his symptoms of distress as a distressed expression, distressed verbalizing, increased agitation, and SIB. It did not describe what SIB the Client exhibited or what need the Client met when he exhibited those behaviors. Record review of Client #6's Annual Healthcare Assessment, dated 07/29/19, showed "Intermittent SIB" as a new problem. It did not describe what SIB the Client exhibited or what need the Client met when he exhibited SIB. Record review of Client #6's Individual Habilitation Plan, dated 08/07/19, showed the Client had exhibited "intense" SIB over the previous year.	{W 214}		

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{W 214}	Continued From page 44 There were no training programs related to SIB in the IHP. During an interview on 08/27/19 at 2:50 PM, Staff G, Psychology Associate, was asked if the Client had been assessed for why he exhibited SIB. Staff G stated that staff told her he had "tummy trouble" and she had not seen the behaviors. Staff G also stated that the Client did not have any training programs in relation to his behaviors.	{W 214}		
W 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete a thorough sensorimotor assessment for walking and the use of orthotics (assistive device to aid with walking) for one of six Sample Clients (Client #3). This failure prevented staff from developing appropriate plans of care to address his ability to walk. Findings included ... Record review of Client #3's Physical Therapy Assessment, dated "03/20/201 [sic]," showed he had a range of motion normal throughout (it did not identify throughout what), but both feet were severely pronated (the soles turned inward) and lower extremities externally (outward) rotated. Adaptive equipment showed foot orthotics. Record review of Client #3's Requested Evaluation, dated 04/30/19, to have his orthotics	W 218		

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W 218	Continued From page 45 fitted to his favorite pair of shoes, showed his custom orthotics would not fit into his favorite shoes and could not be modified to do so. During an interview on 08/22/19 at 1:30 PM, Staff AA, Physical Therapist, stated that he did not evaluate, nor did he know he had to evaluate, the impact of the orthotic use on Client #3's ability to walk and the extent of time needed to use the orthotics each day.	W 218		
{W 220}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete a comprehensive communication assessment for one of six Sample Clients (Client #6). This failure prevented the Client from receiving training to have a viable means of communicating his wants and needs. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Record review of Client #6's Speech-Language Assessment, dated 07/15/19, showed that staff attempted to interpret his needs and preferences due to his inability to communicate in traditional ways. It did not include what barriers to communication were present, what services were available, or what programs/training to provide to address his communication needs.	{W 220}		

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{W 220}	Continued From page 46 During an interview on 08/27/19 at 11:16 AM, Staff F, Qualified Intellectual Disability Professional, stated that the 07/15/19 assessment was the most current assessment.	{W 220}		
W 225	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was a vocational assessment for one of six Sample Clients (Client #5). This failure prevented the facility from knowing the Client's needs related to vocational training and prevented them from developing a plan to meet those needs. Findings included ... Record review of Client #5's Adult Training Programs assessment, dated 04/09/19, assessed his activities in the "Plant Room," but did not assess his strengths and weaknesses related to vocational skills in general. Record review of Client #5's Individual Habilitation Plan (IHP) Addendum, dated 08/19/19, showed he was 54 years old. Nothing in the IHP indicated he was incapable of learning to work. During an interview on 08/21/19, Staff K, Adult Programs Supervisor, stated that they did not do vocational assessments.	W 225		
{W 227}	INDIVIDUAL PROGRAM PLAN	{W 227}		

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{W 227}	Continued From page 47 CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to develop formal training objectives for identified needs for four of six Sample Clients (Client #1, #3, #5 and #6). This failure resulted in the Clients not receiving training to become more independent. This is a repeat citation from the Recertification Survey on 06/04/19. Findings included ... Client #1 A review of Client #1's file and Individual Habilitation Plan (IHP) Addendum, updated 08/05/19, showed a primary need to stabilize his behavioral and chronic illnesses to be able to maintain his Activities of Daily Living (ADL). The IHP also identified needs for Daily Self Help Skills and the use of special training consideration for moderate to severe hearing loss. Client #1's IHP-Addendum showed no formal training plans to maintain his ADLs or to stabilize his chronic illnesses.	{W 227}		

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{W 227}	Continued From page 48 During an interview on 08/27/19 at 10:59 AM, Staff D, Developmental Disabilities Administrator 1, Staff R, Qualified Intellectual Disability Professional (QIDP), and Staff S, Psychology Associate, stated that they had discontinued some formal training programs for Client #1 and new ones, including training on ADLs, were being developed but were not implemented prior to the start of the survey. Client #3 Record review of Client #3's Functional Assessment and Positive Behavior Support Plan (PBSP), dated 03/04/19, showed he grasped others' arms/hands as a form of aggression and also as a form of communication. Record review of Client #3's IHP, dated 04/25/19, showed he did not have a program to replace grasping people's arm. During an interview on 08/22/19 at 1:30 PM, Staff BB, Psychology Associate, stated that Client #3 did not have a program to replace grasping people's arms. Client #5 Record review of Client #5's IHP Addendum, dated 08/19/19, showed he had a primary need to increase cooperation with training tasks. There was no objective to address this need in the IHP. During an interview on 08/28/19 at 11:23 AM, Staff Z, QIDP, stated that Client #5 did not have a	{W 227}		

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{W 227}	Continued From page 49 specific objective to address his need for increased cooperation. Client #6 Cue dependent Observation at Adult Programs, Room 3, at 1:42 PM showed Client #6 smashed aluminum cans with an electronic smasher as staff stood next to him. When the staff member walked away, Client #6 stopped working. When staff would cue the Client to continue smashing the cans, he did. When staff walked away, the Client sat idle. Record review of Client #6's Comprehensive Functional Assessment of Adult Training Programs, dated 07/03/19, showed the Client worked productively for less than one minute. It identified that Client #6 required constant cueing to remain on task and needed to improve attention to tasks. Record review of Client #6's Annual Nursing Healthcare Review, dated 06/12/19, showed the Client was, "very cue dependent and will often only complete a task when asked to." Record review of Client #6's Physical Therapy Annual Assessment, dated 07/03/19, showed the Client was "cue dependent" to complete tasks. Record review of Client #6's Occupational Therapy Annual Assessment, dated 07/08/19, showed the Client waited for staff to cue him before he completed a task. Record review of Client #6's IHP, dated 08/07/19, showed the Client had a primary need to	{W 227}		

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{W 227}	Continued From page 50 self-initiate activities and rely less on staff cues. The IHP did not include any training programs to decrease the Client's need for staff to cue him to complete tasks. During an interview on 08/27/19 at 2:50 PM, Staff F, QIDP, stated that the Client did not have specific training to decrease the Client's dependence on staff cues to complete tasks. Eating Observation at Apple Cottage on 08/26/19 at 11:46 AM showed Client #6 ate lunch. Direct Care Staff provided a verbal cue of "slow down." Record review of Client #6's Occupational Therapy Annual Assessment, dated 07/08/19, showed the Client ate quickly and staff should monitor him during meals. Record review of Client #6's Annual Nursing Healthcare Review, dated 06/12/19, showed a history of choking when eating too quickly or taking too large of a bite. Record review of Client #6's Speech-Language Assessment, dated 07/12/19, showed the Client required close supervision at meals to decrease how quickly he ate to minimize his risk of choking. Record review of Client #6's IHP, dated 08/07/19, showed Client #6 required cues to eat neatly. It did not address the concern of eating too quickly with the potential of choking. Record review of Client #6's training programs for August 2019 showed no training related to how quickly he ate or how much food to have on his	{W 227}		

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{W 227}	Continued From page 51 utensil. During an interview on 08/27/19 at 2:50 PM, Staff F, QIDP, stated that the Client did not have a training program related to eating. Communication Record review of Client #6's Annual Nursing Healthcare Review, dated 06/12/19, showed the Client did not communicate verbally, would occasionally use sign language for "give help," and staff had to interpret his actions in order to decipher his needs. Record review of Client #6's Psychological Assessment, dated 07/01/19, showed he did not develop language skills. Record review of Client #6's Comprehensive Functional Assessment of Adult Training Programs, dated 07/03/19, showed the Client rarely used intentional communication with staff. It recommended the Client gain communication skills before the facility considered community employment. Record review of Client #6's Speech-Language Assessment, dated 07/12/19, showed the Client did not speak, rarely demonstrated intentional communication, and staff attempted to interpret his needs and preferences. It identified the Client would slide a coffee cup to staff to ask for more coffee, or take staff to a desired item. The assessment recommended staff use sign language and modeling to communicate specific symptoms of pain and discomfort that required nursing care, and with, "consistent modeling and guidance from staff, [Client #6's first name] may	{W 227}		

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{W 227}	Continued From page 52 be more willing to utilize proximity/positioning to express needs." Record review of Client #6's IHP, dated 08/07/19, showed the IHP did not contain any training programs to improve Client #6's ability to communicate his wants and needs. During an interview on 08/27/19 at 2:50 PM, Staff F, QIDP, stated that Client #6 did not have any training programs to increase his ability to communicate.	{W 227}		
W 230	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(ii) The objectives of the individual program plan must be assigned projected completion dates. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure two of six Sample Clients (Clients #4 and #6) had projected completion dates for training objectives which were individualized and based on their rates of learning. This failure kept Clients on programs longer than necessary and prevented increased learning opportunities. Findings included ... Client #4 Record review of Client #4's file showed six formal programs that all contained the same estimated completion criteria of 80% for four weeks. The programs were to: Pick up the medication blister pack; Turn on the tub water; Put her money in her money pouch; Make a drink	W 230		

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W 230	Continued From page 53 choice using her iPad; Maintain walking around the Evergreen courtyard sidewalk loop; and utilize communication picture cards to choose an activity. These programs contained varying levels of complexity, yet had the same completion success rate. During an interview on 08/27/19 at 11:31 AM, Staff D, Developmental Disabilities Administrator 1, Staff P, Qualified Intellectual Disability Professional (QIDP), and Staff Q, Attendant Counselor Manager, stated that the duration of Client #4's programs should not be the same. Client #6 Record review of Client #6's current training plans for turning on a machine, wearing gloves while smashing aluminum cans, shaving the right side of his face, pouring mouthwash in a cup, and identifying a nickel showed the programs all had the same estimated completion criteria of 80% for four weeks. During an interview on 08/27/19 at 9:27 AM, Staff E, Registered Nurse, stated that the facility "benchmark" for training programs to be considered successful was completion at 80 % for four weeks. During an interview on 08/27/19 at 2:50 PM, Staff F, QIDP, stated that the success criteria was not established based on the Client's rate of learning.	W 230		
{W 234}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(i) Each written training program designed to implement the objectives in the individual	{W 234}		

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{W 234}	Continued From page 54 program plan must specify the methods to be used. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that one of six Sample Clients (Client #6) had teaching programs with clear, detailed instructions. This failure resulted in inconsistent training for Client #6 and prevented his progression toward learning the skill. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Observation at Apple Cottage on 08/20/19 at 8:50 AM showed Staff J, Licensed Practical Nurse, placed a laminated picture of two white pills on the table in front of Client #6. Record review of Client #6's Self-Med Recording/Information Form K.18, showed staff were to set a laminated picture of medication in front of him. The training instructions stated that staff should have the laminated picture card of sign language for "medication" to use for the teaching program. Staff were to ask the Client to show the sign for "medication," then demonstrate the sign, and show him the card. During an interview on 08/27/19 at 9:27 AM, Staff E, Registered Nurse, stated that the teaching plan gave conflicting information on which picture to use during training. Record review of Client #6's Program Description Form D.08, showed the Client was to learn to scoop food onto his plate. The form directed staff	{W 234}		

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{W 234}	Continued From page 55 to implement the training program "after" each meal. Record review of Client #6's Program Description Form J.42, for vocational training, and C.21, for increasing dental hygiene skills, showed a statement that the Client needed to be within arm's reach of staff due to the potential for him to, "lick the lotion off of his hand." Neither program had anything to do with lotion nor was lotion used in the training program. During an interview on 08/27/19 at 2:50 PM, Staff F, Qualified Intellectual Disability Professional, stated that staff did not update the content on the program forms when the training plans changed.	{W 234}		
W 236	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(5)(iii) Each written training program designed to implement the objectives in the individual program plan must specify the person responsible for the program. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the Qualified Intellectual Disability Professionals (QIDPs) for two of six Sample Clients (Clients #4 and #6) were familiar with the assessment, implementation, and data collected for training programs by the staff assigned to be responsible for them. This failure prevented Clients from having staff who knew when Clients had been successful with training programs. Findings included ...	W 236		

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W 236	Continued From page 56 Client #4 Record review of Client #4's Quarterly Report-Psychology Services, dated 05/21/19, completed by Staff II, Psychology Associate, showed analysis of the Client's target behaviors. One of the listed target behaviors consisted of three distinct behaviors of "intentional incontinence/stripping/emesis [vomiting]." Record review of the data tracking logs showed the facility used one code to track three behaviors. Further review of the Quarterly Report-Psychology Services, dated 05/21/19, showed nothing to indicate which of the three behaviors the data applied to. The total monthly data figures were in values of minutes, months, or no value, so there was no way to provide a meaningful analysis. During an interview on 08/27/19 at 11:31 AM, Staff P, QIDP, stated that she was unaware of this problem until pointed out by the State Surveyor. Client #6 Observation at Adult Programs (AP), Room #3, on 08/19/19 at 1:42 PM showed Client #6 independently turned on the can smasher, placed aluminum cans in the machine, and smashed the cans. At 1:47 PM, Client #6 turned the machine off. AP staff instructed Client #6 to turn the machine back on and he independently did so. Record review of Client #6's Adult Program Description Form J.42 showed the Client was to independently turn on a cardboard baler when directed by staff with a completion rate of 80% for	W 236		

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W 236	Continued From page 57 four continuous weeks to pass on to the next step of the training. Record review of Client #6's Program Recording Form for J.42 for June 3-28, 2019 showed he independently turned on the baler as instructed with 85% success. There was no indication the facility moved the Client to the next step of the training program. Record review of Client #6's Individual Habilitation Plan Addendum, dated 07/11/19, showed Staff K, Adult Program Supervisor, reviewed the program and did not pass the Client on to the next objective. During an interview on 08/28/19 at 11:16 AM, Staff F, QIDP, stated that they did not analyze program data, they relied on others' analyses to determine if the Client should progress to the next step of training. Further review of Client #6's Program Recording Forms for his objectives showed the statement, "If the resident has at least 10 consecutive days of successful completion of the objective, the IDT [Interdisciplinary Team] may determine to achieve and advance the objective regardless of the indicated success criteria of the program." During an interview on 08/28/19 at 11:16 AM, Staff F, QIDP, stated that she had checked with all the QIDPs on campus and none of them knew the statement about the 10 consecutive days of successful completion for objectives was on the data collection sheets.	W 236		
{W 242}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii)	{W 242}		

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{W 242}	Continued From page 58 The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure four of six Sample Clients (Clients #1, #2, #3, and #4) had training for all identified needs related to Activities of Daily Living (ADLs) and communication. This failure resulted in a lack of training in basic skill areas to increase independence for these Clients. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Client #1 Review of Client #1's file revealed an Individual Habilitation Plan (IHP) Addendum, updated 08/05/19, that showed a primary need to, "stabilize his behavioral and chronic illnesses to be able to maintain his ADLs." Client #1's IHP-Addendum showed no formal training programs to maintain his ADLs. During an interview on 08/27/19 at 10:59 AM, Staff D, Developmental Disabilities Administrator 1 (DDA1), Staff R, Qualified Intellectual Disability Professional (QIDP), and Staff S, Psychology	{W 242}		

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{W 242}	Continued From page 59 Associate, stated that programs to train ADLs were being developed but were not implemented prior to the start of the survey. Client #2 Record review of Client #2's Direct Care Independent Living Skills Assessment, dated 05/15/19, showed recommendations for training to increase independence with ADLS in the following areas: personal hygiene, grooming, dental hygiene, and dressing. Record review of Client #2's Occupational Therapy Annual Assessment, dated 05/24/19, showed recommendations to continue to train him to increase independence with ADLs. Record review of Client #2's IHP, dated 06/26/19, showed no training objectives for personal hygiene, grooming, dental hygiene, or dressing. During an interview on 08/26/19 at 1:30 PM, Staff P, QIDP, stated that Client #2 could have more objectives for his ADLs and that she needed to update his IHP. Client #3 Record review of Client #3's IHP/Discharge Plan, dated 08/13/19, showed he had a need to increase use of alternative communication systems to express his preferences/choices. Record review of Client #3's IHP, dated 04/25/19, and with a hand written note that indicated, "Changed per POC [Plan of Correction] 08/13/19," showed he had no formal objective or training program for communication.	{W 242}		

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{W 242}	Continued From page 60 During an interview on 08/21/19 at 9:00 AM, Staff V, QIDP, stated that Client #3 currently did not have a formal training program for communication. Client #4 Record review of a Direct Care Independent Living Skills Assessment, dated 01/27/19, showed Client #4 required one-to-one (1:1) supervision to bathe and assistance with dressing, tooth brushing, applying deodorant, fingernail care, brushing & styling her hair, wiping herself after toileting, making her bed, folding clothing, keeping her room tidy, walking on uneven surfaces, using stairs, crossing the street, fastening & unfastening seatbelts, responding to directions in an emergent situation, recognizing unsafe environments, participating in exercise & sports, and identifying signs in the community. Review of Client #4's file showed an IHP, dated 03/06/19, that documented that the Interdisciplinary Team decided her primary need was to decrease maladaptive behaviors while increasing daily living skills. There were no objectives for skill training in ADLs. Record review of an IHP-Addendum, dated 03/06/19, showed an objective to use communication cards to choose an activity. There was a comment in the Non-Programmed Services section of the addendum to develop programs to teach Client #4 to use her iPad to increase her communication abilities. During an interview on 08/27/19 at 11:31 AM, Staff D, DDA 1, Staff P, QIDP, and Staff Q, Attendant Counselor Manager, stated that Client	{W 242}		

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{W 242}	Continued From page 61 #4 needed more than one program to train her on the use of the iPad to communicate, and not all of her identified needs for ADLs had objectives and training programs.	{W 242}		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide opportunities to allow two of six Sample Clients (Client #1 and #3) and one Expanded Sample Client (Client #9) to makes personal choices. This failure resulted in a lack of choice for Clients and missed training opportunities. Findings included ... Client #1 Observation on 08/20/19 from 8:21 AM to 9:37 AM at Hillside Cottage showed Client #1 rinsed and put his dishes in a rack at Staff's request. Staff assisted Client #1 to put on his wrist watch, put on his elbow and knee pads and assisted him with brushing his teeth and combing his hair. Client #1 refused when staff asked him to help some more with dishes. Another staff got Client #1 a glass of water and a rag. Observation on 08/27/19 from 7:07 AM to 8:15 AM showed Client #1 prepared his breakfast. A Direct Care Staff (DCS) verbally cued him through making toast and dishing up scrambled	W 247		

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W 247	Continued From page 62 eggs. The DCS provided physical assistance when they opened the bread bag, brought Client #1 a container of butter, opened the container of scrambled eggs, and closed and put away the container of nutria-grain bars. An Adult Training Staff helped Client #1 cut up his egg sandwich. Review of Client #1's Individual Habilitation Plan (IHP), updated 08/05/16, showed he, "is very capable of performing most daily living skills independently including toileting, eating, and dressing." Client #1 required verbal assistance with grooming Activities of Daily Living (ADL). During an interview on 08/27/19 at 10:59 AM, Staff D, Developmental Disabilities Administrator 1, Staff R, Qualified Intellectual Disability Professional (QIDP), and Staff S, Psychology Associate, stated that staff should not be doing things for Client #1 because he was capable of doing them for himself. Client #3 Observation on 08/20/19 from 9:45 AM to 10:04 PM at Adult Programs, Room #15, showed staff put a video on the iPad for Client #3 to watch. Staff attempted to get Client #3 to cut paper, but he only participated when Staff provided full physical assistance. Staff asked Client #3 what he wanted for snack. He independently selected water using the iPad. Staff then asked him what he wanted as the snack. Client #3 ignored this question from staff. Staff asked a second time. Client #3 ignored the second asking. Staff used full physical assistance to move Client #3's hand and selected graham crackers on the iPad.	W 247		

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W 247	Continued From page 63 Record review of Client #3's IHP, dated 08/13/19, showed Client #3 had the capability to use the iPad and can make cognitive, individualized choices. During an interview on 08/21/19 at 9:00 AM, Staff V, QIDP, stated that staff should allow Client #3 to make his own choices for snack, including but not limited to, when he does not choose one. Client #9 Observation on 08/26/19 at 4:40 PM at Hillside Cottage showed Client #9 asked staff for a soda with dinner multiple times. Staff denied Client #9 access to her soda. Staff told Client #9 she was only allowed soda at 2:00 PM daily. Record review of Client #9's IHP, dated 08/05/19, showed Client #9 had no restrictions to her diet or on her access to soda. During an interview on 08/27/19 at 4:15 PM, Staff R, QIDP, and Staff W, Attendant Counselor Manager, stated that Client #9 had access to her soda whenever she chose.	W 247		
{W 251}	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.	{W 251}		

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{W 251}	Continued From page 64 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff implemented training programs as written for two of six Sample Clients (Client #3 and #6). This failure prevented the Clients from learning the intended skills identified by the facility. This is a repeat citation from the Recertification Survey on 06/14/19. Findings included ... Client #3 Record review of Client #3's Individual Habilitation Plan Addendum, dated 08/19/19, showed program K.08, "[Client #3's first name] will sign "medication" before receiving his medicine." P1 (staff assist by physically directing the movement by touching the Client's wrist) was listed as the level of support given. Observation on 08/20/19 at 9:02 AM at Pinewood Cottage showed nursing staff asked Client #3 to sign "medication." Client #3 did not respond to the cue. Nursing staff proceeded to grab Client #3's hands and manipulate them into creating the sign for "medication." During an interview on 08/21/19 at 9:00 AM, Staff V, Qualified Intellectual Disability Professional, stated that nursing staff should have only assisted Client #3 in signing "medication" and not provided full physical assistance.	{W 251}		

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{W 251}	Continued From page 65 Client #6 Record review of Client #6's Self-Med Program Recording/Information Form K.18 showed staff were to use a laminated picture of sign language for "medication" during the implementation of the training program, set his medications in front of him, and sign the word "medication" as they showed the picture to Client #6. Observation at Apple Cottage on 08/20/19 at 8:50 AM showed Staff J, Licensed Practical Nurse (LPN), placed a laminated picture of two white pills on the table in front of Client #6. Client #6 tapped the picture of the medication and the LPN stated, "Good job." During an interview on 08/20/19 at 2:02 PM, Staff J stated that Client #6 did not like the new training program so she used the old card instead. During an interview on 08/27/19 at 9:27 AM, Staff E, Registered Nurse, stated that the LPN should have used the correct card during the training program.	{W 251}		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have or implement systems to ensure they provided health care for identified acute and chronic needs for two of six	W 318		

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W 318	Continued From page 66 Sample Clients (Clients #2 and #6) and one Expanded Sample Client (Client #8). This failure resulted in unnecessary extended illness for Client #2 and placed all Clients at risk to develop a severe and dangerous illness. This failure resulted in an Immediate Jeopardy. Findings included ... Record review and interview showed the facility failed to develop and implement a written, comprehensive plan of care that directed all staff at the facility on how to care for Sample Client #2 after a return from the hospital for surgery. This resulted in serious medical complications for Client #2. This resulted in an Immediate Jeopardy. See W320 for details. Record review and interview showed the facility failed to provide physician services for Sample Clients #2 and #6. This resulted in Client #8 contracting the same identified E coli bacteria from Client #2. This resulted in an Immediate Jeopardy. See W322 for details. Observation, record review, and interview showed the facility failed to ensure Sample Client #6 received a follow up medical evaluation from a Gastroenterologist. This left the Client at risk for serious complications related to his medical condition. See W338 for details. Observation, record review, and interview showed the facility failed to ensure Sample Clients #2 and #6 had appropriate nursing interventions implemented. This resulted in a need for hospitalization for Client #2, and put Clients at risk for serious complications related to their	W 318		

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W 318	Continued From page 67 medical needs. This resulted in an Immediate Jeopardy. See W339 for details. Record review and interview showed the facility failed to ensure there was a written agreement with a licensed dental provider to ensure all Clients were able to receive emergent dental care. See W355 for details. Observation, record review, and interview showed the facility failed to administer medications as ordered. See W368 for details.	W 318		
W 320	PHYSICIAN SERVICES CFR(s): 483.460(a)(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement a written, comprehensive plan of care for one of six Sample Clients (Client #2) after he returned to the facility from undergoing outpatient surgery. This failure resulted in additional medical complications for Client #2 and caused him to return to the hospital. This resulted in an Immediate Jeopardy. Findings included ... Review of Client #2's file showed the following:	W 320		

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W 320	Continued From page 68 a. Sacred Heart Medical Center History and Physical, dated 08/05/19, showed he was diagnosed with [redacted] b. An Infectious Disease Physician, who ordered Bactrim (an antibiotic), saw him on 06/06/19. The facility did not follow the Infectious Disease Specialist's recommendations to use Bactrim. There was no documentation as to why the facility chose not to follow the specialist's recommendations. c. An Interdisciplinary Case Conference Note, dated 06/11/19, showed the Client was hospitalized from [redacted]/19 through [redacted]/19 because of a UTI, fever, decreased oxygen levels in his blood, and lack of sleep for approximately 31 hours. d. An Interdisciplinary Team (IDT) meeting was held on [redacted]19 to discuss the plan of care for Client #2 upon his return from the hospital. The Interdisciplinary Case Conference Note, dated [redacted]19, showed the Client would finish the antibiotics the hospital prescribed, and then start a 6-week course of a different antibiotic rather than the one the Infectious Disease Physician recommended on 06/06/19. There was no documentation regarding why the IDT decided not to follow the specialist's recommendations. The Case Note also showed Client #2 was scheduled for surgery on [redacted]19 to have a suprapubic catheter (a device inserted into the bladder to drain urine if one can't urinate on their own) placed.	W 320		

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W 320	Continued From page 69 Record review of Discharge Instructions, dated [redacted]19, from the surgery to place a suprapubic catheter showed : He was to drink eight glasses of water a day. Medical care was to be sought if he leaked urine, the skin around the catheter became red or sore, or if urine flow slowed down. Immediate medical care was to be sought if he had no urine flow for one hour. Record review of Client #2's Intake and Output Worksheets, filled out by DCS, showed: 1. For 07/19/19- all shift sections were left blank 2. For 07/22/19- the 7 AM-3 PM shift noted Client #2 voided 200ml (milliliters) from his urethra. 3. For 07/27/19- only the 7 AM-3 PM shift noted a fluid intake of 440ml. No shift noted any output of fluids from the catheter or through the urethra. 4. For 08/01/19- the 7 AM-3 PM shift noted 1193ml of fluid intake and 70ml of output. The 3 PM-11 PM shift noted fluid intake of 1140ml and 550ml of output. 5. For 08/02/19- the 7 AM-3 PM shift noted 720ml of fluid intake and 25ml of output, they also noted that Client #2's urine collection bag had detached about noon and urine soaked his clothes so they were unable to determine accurate output. For the 3 PM-11 PM shift, staff noted 1200ml of intake and that they were unable	W 320		

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W 320	Continued From page 70 to determine output because the bag had disconnected again. Record review of Client #2's Interdisciplinary Progress Notes showed the following: 1. 07/03/19- Client #2 continued to have some drainage from his stoma site and mild symptoms of mania (not sleeping, restless). 2. 07/05/19- At 8:15 PM Client #2 had sediment present in his urine drainage bag. 3. 07/06/19- At 4:20 PM Client #2 said, "My kidneys hurt," and had periods of crying. 4. 07/07/19- At 2:00 PM Client #2's surgical incision was pink, the tube was being pulled out and the urine holder on the side was too far down his thigh. At 9:10 PM, the insertion site was pink and his urine drainage bag contained sediment. 5. 07/11/19- At 6:10 AM Client #2 was incontinent (urine leaked from his penis). 6. 07/12/19- At 10:30 PM Client #2 was incontinent three times during the shift. 7. 07/13/19- At 2:00 PM Client #2 was incontinent four times during the shift. 8. 07/20/19- At 2:20 PM Client #2 had wet through his pants. 9. 07/30/19- At 6:15 AM Client #2 was resistant to eating and drinking and did not want to take his medications. 10. 08/04/19- Staff noted throughout the day	W 320		

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W 320	Continued From page 71 that Client #2 was screaming, agitated, struck at staff, refused food and liquids, refused medications, and had no output of fluids nor bowel movements. 11. There was no documentation that nursing staff had analyzed his intake and output ratio or otherwise assessed for dehydration. There was no documented assessment of his signs and symptoms of a Urinary Tract Infection (UTI). Further review of Client #2's file showed: The file showed it did not contain a comprehensive medical care plan created by the physician in conjunction with nursing to ensure all staff that worked with Client #2 knew how to provide care for him post-surgery. Client #2's Interdisciplinary Progress Notes showed from [redacted]19, until he returned to the hospital on [redacted]19, that he experienced drainage from the catheter site, sediment in the drainage bag, kidney pain, incontinence from the urethra, lack of eating and drinking, restlessness and agitation, and refused medications. On [redacted]19, 35 days after the surgery to place the suprapubic catheter, he was re-admitted to Sacred Heart Medical Center Emergency Room for dehydration, UTI, and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition, such as viral infection or toxins in the blood). Sacred Heart Medical Center History and Physical, dated [redacted]19, showed he was placed	W 320		

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W 320	Continued From page 72 in 4-point mechanical restraints due to aggressive behavior, given IV (intravenous-directly into the bloodstream) antibiotics, and anticipated he would be hospitalized for more than two days. While in restraints it was identified that he had an unresolved fracture to his right arm near his shoulder. Hospital nurse to Lakeland Village nurse documentation of communication regarding the return of the Client to the facility, dated 08/06/19, showed he received multiple IV antibiotics. Sacred Heart Medical Center Assessment of Active Problems, dated 08/07/19, showed the Client's urine culture was positive for E-coli and noted he was switched to the antibiotic Bactrim based on the Infectious Disease Physician's recommendation on 06/06/19. This document identified he continued to try to hit care workers due to his UTI and encephalopathy and was in 4-point mechanical restraints which were reviewed for continuation of use every four hours. A Sacred Heart Medical Center shift-to-shift Nursing Handoff Note, dated 08/07/19, showed the Client was aggressive towards staff and was in "violent restraints." A RHC (Residential Habilitation Center) Incident Report Director's Review Form, dated 08/09/19, showed that the low urine output in Client #2's urine collection bag should have resulted in an assessment to determine the cause of the low output. The urinary incontinence with the catheter should have resulted in an assessment. After the investigating nurse reviewed the Client's Intake	W 320		

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W 320	Continued From page 73 and Output Records, she identified a significant decline that signaled a change in condition. During an interview on 08/21/19 at 3:10 PM, Staff I, Advanced Registered Nurse Practitioner, Staff M, Registered Nurse (RN) 2, Staff P, Qualified Intellectual Disabilities Professional, and Staff JJ, RN 4, were asked if there was a medical care plan for Client #2's bladder condition. They stated that they did not create a comprehensive plan of care for Client #2, nor could they provide documentation that all staff working with Client #2 were trained on how monitor, report, and address his medical issues when he returned to the facility.	W 320		
W 322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure they had a system in place to provide preventive and routine medical services in accordance the identified needs for two of six Sample Clients (Client #2 and #6). This resulted in one Expanded Sample Client (Client #8) getting an infection from Client #2. This failure prevented the facility from providing appropriate medical care for Client #2 and left all Clients at Cascade Cottage at unnecessary risk for infection. This failure also resulted in missed diagnostic testing for Client #6, that left all Clients at risk for harm related to not having their medical care needs met.	W 322		

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W 322	Continued From page 74 This resulted in an Immediate Jeopardy. Findings included ... Client #2 Review of Client #2's medical file showed: a. He was diagnosed with [redacted] b. An Infectious Disease Physician, who ordered Bactrim (an antibiotic), saw him on 06/06/19. The facility did not follow the Infectious Disease Specialist's recommendations and give the Client Bactrim. There was no documentation as to why the facility chose not to follow the specialist's recommendations. c. On 06/11/19, the facility held an Interdisciplinary Team (IDT) meeting to discuss the plan of care for Client #2. The Interdisciplinary Case Conference Note, dated 06/11/19, showed the Client was hospitalized from [redacted]19 through [redacted]19 because of a UTI, fever, decreased oxygen levels in his blood, and lack of sleep for approximately 31 hours. The note indicated the Client would finish the antibiotics the hospital prescribed, and then start a 6-week course of a different antibiotic than the one the Infectious Disease Physician recommended on 06/06/19. There was no documentation regarding the IDTs decision not to follow the specialist's recommendations.	W 322		

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W 322	Continued From page 75 During an interview on 08/21/19 at 3:10 PM, Staff JJ, Registered Nurse (RN), stated that the IDT discussed the use of antibiotics but they did not document the results of their decision. Staff JJ stated that the facility did not have a process to acknowledge or address outside medical provider recommendations. Further review of Client #2's file showed: d. On [redacted]19, Client #2 had outpatient surgery to place a suprapubic catheter (a surgically placed tube going through his lower belly into his bladder to drain urine) due to his inability to pass urine, which led to frequent UTI's. e. There was no comprehensive medical care plan related to the [redacted]19 surgery, created by the physician in conjunction with nursing staff, to ensure all staff that worked with Client #2 knew how to provide care for him after surgery to promote recovery and healing. During an interview on 08/21/19 at 3:10 PM, Staff I, Advanced Registered Nurse Practitioner (ARNP), Staff M, RN 2, Staff P, Qualified Intellectual Disabilities Professional (QIDP), and Staff JJ, RN 4, stated that they did not create a comprehensive plan of care for Client #2 after his suprapubic catheter was placed. Continued review of Client 2"s file showed: f. Per Interdisciplinary Progress Notes, from [redacted]19 to [redacted]19, Client #2 experienced drainage from the catheter site, sediment in the urine drain bag, kidney pain, incontinence (leaked urine) from his penis, he was not eating or	W 322		

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W 322	Continued From page 76 drinking, restlessness and agitation, and refused medications. g. On [redacted]19, Client #2 was admitted to Sacred Heart Medical Center Emergency Room for dehydration, UTI, and encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition, such as viral infection or toxins in the blood). The Client required 4-point mechanical restraints while in the hospital due to his agitated state. h. While at the hospital on [redacted]19, he was treated with Bactrim, the same medication the Infection Specialist prescribed, for his UTI. i. On 08/13/19, a repeat urine culture showed the antibiotics had cleared the multiple drug resistant infection, E-coli Extended Spectrum Beta Lactamase. During an interview on 08/21/19 at 3:10 PM, Staff ARNP, Staff M, RN 2, Staff P, QIDP, and Staff JJ, RN 4, stated that there was no comprehensive plan to care for Client #2 when he had a change of condition. There was no training documented for the staff that worked with Client #2 so they knew how to provide care for him upon his return to the facility after having surgery to place the catheter. Review of Client #8's file showed he lived at Cascade Cottage with Client #2. Record review of Client #8's urine culture, dated 07/19/19, showed he had an E-coli Extended Spectrum Beta Lactamase (bacteria that is	W 322		

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W 322	Continued From page 77 resistant to 5 different antibiotics) bladder infection. Client #2 had the same bacterial infection on [redacted]19 when he returned from a hospital stay for a UTI. Record review of a Staff Development Attendance Record Specialized Training sheet, dated 08/02/19, showed, "subject: Hand washing and sanitation of surfaces and equipment to prevent spread of infection." It showed that Client #8 had the same bacterial UTI as Client #2 and there was a concern that staff had contaminated items within the cottage, indirectly causing Client #8's infection. It showed instruction for wearing gloves, handling dirty linen or other contaminated equipment, and sanitizing surfaces to avoid the spread of infection from one resident to another. The in-service was intended for Licensed Nurses, not direct care staff providing care for Client #8 or Client #2. Client #6 Record review of Client #6's cardiology (heart specialist) appointment report, dated 01/11/18, showed a physician order to repeat the echocardiogram (a test to determine how well blood flows through the heart) in one year. Review of Client #6's file showed no echocardiogram results for 2019. During an interview on 08/27/19 at 9:27 AM, Staff E, RN, stated that the facility did not ensure that an echocardiogram was completed in 2019 as ordered. During an interview on 08/21/19 at 3:10 PM, Staff JJ, RN, stated that the facility did not have a	W 322		

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W 322	Continued From page 78 process to address recommendations when a Client returned to the facility after seeing a community medical provider.	W 322		
W 338	NURSING SERVICES CFR(s): 483.460(c)(3)(v) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one of six Sample Clients (Client #6) received a follow up medical evaluation from a Gastroenterologist (a physician specializing in digestive issues). This failure prevented management of Client #6's chronic constipation that left him at risk for serious complications related to his chronic constipation. Findings included ... Observation at Apple Cottage on 08/20/19 at 8:29 AM showed Client #6 helped clear the table after breakfast was done. Observation at Apple Cottage on 08/20/19 at 8:50 AM showed a Licensed Nurse administered Linzess 290 micrograms (a prescription medication that treats constipation) to Client #6. Record review of the manufacture's patient instructions for the administration of Linzess, located at	W 338		

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W 338	Continued From page 79 https://www.allergan.com/assets/pdf/linzess_pi, showed the medication was to be taken at least 30 minutes before the first meal of the day. Record review of Client #6's Annual Healthcare Assessment, dated 07/29/19, showed Client #6 had [redacted] and [redacted]. It identified the last diagnostic testing for these diagnoses occurred on 09/23/13. Record review of Client #6's Physician Order renewal, dated 07/10/19, showed Client #6 routinely took 10 different medications to manage his digestive issues. The most recent medication change occurred on 03/06/19 when the facility's Advanced Registered Nurse Practitioner added Linzess. The order did not include the instructions to take the medication at least 30 minutes before breakfast. Record review of Client #6's Nutritional Assessment, dated 06/28/19, showed staff treated the Client 18 times in six months for abdominal distention, discomfort, constipation, yelling, and hitting himself, and referenced abdominal x-ray results that indicated the possibility of a condition where his intestines were not moving the contents. During an interview on 08/27/19 at 8:55 AM, Staff N, Clinical Pharmacist, stated that the facility reviewed the Client medications monthly and it was not unusual for Clients to take multiple different medications for one diagnosis. Staff N stated that she was not responsible for the referral to specialized physicians, such as a gastroenterologist.	W 338		

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LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 338	Continued From page 80 During an interview on 08/27/19 at 9:27 AM, Staff E, Registered Nurse, stated that Client #6 should have been seen by a gastroenterologist annually.	W 338		
W 339	NURSING SERVICES CFR(s): 483.460(c)(4) Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure two of six Sample Clients (Clients #2 and #6) had appropriate nursing interventions implemented. This failure left the Clients at risk for serious complications related to their unmet medical needs and contributed to the hospitalization of Client #2. This resulted in an Immediate Jeopardy. Findings included ... Client #2 Record review of Client #2's chronic (on-going) Plan of Care, dated 06/18/16 through 06/20/20, showed the following instructions: 1.Direct Care Staff (DCS) were to report any leaking of the catheter (tube through which urine exited the body), decreased amount of urine in the bag, complaint of discomfort, foul odor, cloudy urine, and bloody or dark urine. 2.DCS were to notify the nurse of changes in eating, drinking, sleeping, urination (lack of), activity, and alertness.	W 339		

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W 339	Continued From page 81 3.DCS to encourage 8-10 glasses of fluids per day and record on the Intake and Output form. 4. Nursing to monitor intake and output (of fluids) on the form each shift. 5.Nursing Post Op (after surgery) stoma (an opening in the body) care as ordered by surgeon contained instructions to notify the resource nurse of increased redness, warmth, discomfort, or drainage from the area. 6. DCS and Nursing were to monitor if Client #2 refused food and/or fluids, monitor intake and output carefully, and report immediately any decrease in urine output or voiding from his urethra to the nurse/resource nurse for further evaluation. Record review of Client #2's Intake and Output Worksheets, filled out by DCS, showed the following: a. For 07/19/19- all shift sections were left blank b. For 07/22/19- the 7 AM-3 PM shift noted Client #2 voided 200ml (milliliters) from his urethra. c. For 07/27/19- only the 7 AM-3 PM shift noted a fluid intake of 440ml. No shift noted any output of fluids from the catheter or through the urethra. d. For 08/01/19- the 7 AM-3 PM shift noted 1193ml of fluid intake and 70ml of output. The 3 PM-11 PM shift noted fluid intake of 1140ml and 550ml of output. e. For 08/02/19- the 7 AM-3 PM shift noted 720ml of fluid intake and 25ml of output, they also noted that Client #2's urine collection bag had detached about noon and urine soaked his clothes so they were unable to determine	W 339		

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W 339	Continued From page 82 accurate output. For the 3 PM-11 PM shift, staff noted 1200ml of intake and that they were unable to determine output because the bag had disconnected again. Record review of Client #2's Health Monitoring Flow Sheet for Intake and Output Documentation for the months of July 2019 and August 2019, to be completed by nursing, showed the following omissions: 1. For 07/13/19- no output information on the 7 AM-3 PM shift. 2. For 07/22/19- no intake or output information on the 3 PM-11 PM shift. 3. For 07/25/19 and 07/29/19- no intake or output information for any shift. 4. For 08/04/19- no intake information for any shift. Record review of Client #2's Interdisciplinary Progress Notes showed the following: 07/01/19- Client #2 attempted to grab and pick at his dressing. 07/03/19- Client #2 continued to have some drainage from his stoma site and mild symptoms of mania (not sleeping, restless). 07/05/19- At 6:30 AM Client #2 needed constant redirection to stop him from pulling at his catheter tube site. 07/05/19- At 8:15 PM Client #2 had sediment present in his urine drainage bag. 07/06/19- At 4:20 PM Client #2 said, "My kidneys hurt," and had periods of crying.	W 339		

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W 339	Continued From page 83 07/07/19- At 2:00 PM Client #2's surgical incision was pink, the tube was being pulled out and the urine holder on the side too far down his thigh. At 9:10 PM, the insertion site was pink and his urine drainage bag contained sediment. 07/11/19- At 6:10 AM Client #2 was incontinent (urine leaked from his penis). 07/12/19- At 10:30 PM Client #2 was incontinent three times during the shift. 07/13/19- At 2:00 PM Client #2 was incontinent four times during the shift. 07/20/19- At 2:20 PM Client #2 had wet through his pants. 07/30/19- At 6:15 AM Client #2 had been awake all of shift three (the night shift) and was agitated and restless. At 10:30 PM staff noted he required constant redirection from yelling and striking out at staff, and he was unable to maintain focus on a singular task without becoming aggressive. He was resistant to eating and drinking and did not want to take his medications. 08/04/19- Staff noted throughout the day that Client #2 was screaming, agitated, struck at staff, refused food and liquids, refused medications, and had no output of fluids nor bowel movements. Review of Client #2's file showed no documentation that nursing staff analyzed his intake and output ratio and there was no assessment for dehydration or his signs and symptoms of a Urinary Tract Infection (UTI).	W 339		

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W 339	Continued From page 84 Client #2 was hospitalized on [redacted]19, diagnosed with a [redacted] and [redacted] The Client required 4-point mechanical restraints while in the Emergency Room due to his agitated state. During an interview on 08/22/19 at 10:13 AM, Staff JJ, Registered Nurse 4, stated that any changes in condition should be charted in progress notes and any concerns reported to the facility Resource Nurse. Staff JJ stated that nursing staff did not complete required documentation. Staff JJ stated that they did not have an adequate process to ensure that nurses and DCS documented and followed up on concerns so that the facility's physician was aware of Clients' physical condition. Client #6 Observation at Apple Cottage on 08/20/19 at 8:28 AM showed Client #6 sat at the kitchen table, rocking and slapping his stomach. DCS stated, "[Client #6's first name] we are getting you a PRN [as needed medication]." At 8:35 AM, Staff J, Licensed Practical Nurse, prepared and administered Client #6's morning medications but did not provide a PRN to Client #6. Record review of Client #6's physician orders for medications, dated 07/10/19, showed Client #6 had the following PRN medications ordered: Tylenol- every 6 hours as needed for discomfort or fever	W 339		

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W 339	Continued From page 85 Bisacodyl suppository- once daily as needed for increased agitation/constipation Ibuprofen- every 6 hours as needed for pain or discomfort Tramadol (prescription pain medication) - every 12 hours as needed for muscle pain The physician orders did not provide direction to staff for the evaluation of the Clients agitation, did not indicate which PRN medication staff would utilize first, how to determine how long to wait to treat with an alternate medication, or provide parameters for giving the over-the-counter medication versus the prescription pain medication. Review of Client #6's Interdisciplinary Progress Notes showed the following entries: 07/11/19- ibuprofen given for self-injurious behaviors (SIB) 07/12/19- suppository given for SIB 07/15/19- Client #6 moaning, abdomen bloated, gave ibuprofen 07/19/19- Client #6 hitting himself in genitals, slapping stomach, gave suppository 07/26/19- Client #6 moaning and squinting his eyes, suppository given, behavior continued and nurse gave ibuprofen 07/28/19- Client #6 moaning and slapping his stomach, gave prune juice, gave suppository afterward 07/31/19- Client #6 showing signs and symptoms	W 339		

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W 339	Continued From page 86 of pain by SIB, gave ibuprofen 08/01/19- SIB, suppository given, continued SIB, ibuprofen given 08/02/19- Tramadol given for increased SIB, slapping self on head and stomach, increased restlessness 08/05/19- Client #6 slapping hands, rocking back in chair, moaning, ibuprofen given 08/11/19- Client #6 slapping his stomach, given PRN medication. 15 minutes later Client running down halls, hitting himself and vocalizing, notified the nurse SIB was escalating, gave him a suppository then he began jumping on his bed, yelling loudly and hitting himself harder. Nurse gave ibuprofen and the Client calmed an hour later 08/15/19- Ibuprofen given for agitation, suppository given afterward 08/18/19- Client #6 appeared distressed, hitting his stomach and head, face and jaw appears slightly swollen, gave ibuprofen at 12:50 PM. At 1:30 PM, continued restless, hitting self, gave tramadol. SIB increasing, hitting stomach/agitated gave suppository. During an interview on 08/27/19 at 9:27 AM, Staff E, Registered Nurse, stated that the nurse administering the medication would have to determine which one to give as there were no specific directions related to use of the as needed medications. During an interview on 08/27/19 at 2:50 PM, Staff	W 339		

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W 339	Continued From page 87 G, Psychology Associate, stated that staff told her that Client #6 got agitated when he had "tummy problems."	W 339		
W 355	COMPREHENSIVE DENTAL TREATMENT CFR(s): 483.460(g)(1) The facility must ensure comprehensive dental treatment services that include the availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was a written agreement with a licensed dental provider to ensure all Clients were able to receive emergent dental care. This failure prevented Clients from having dental services available in the event of a dental emergency. Findings included ... Record review of Appendix J, dated 04/13/18, Federal Code of Regulations 483.460(g)(1), for Intermediate Care Facilities, showed that the facility must have a written agreement with a licensed dentist to provide 24/7 guidance and/or provision of emergency dental services for Clients at the facility. During an interview on 08/26/19 at 10:29 AM, Staff B, Assistant Superintendent, stated that the facility did not have a written agreement with a dental provider for emergent dental care 24 hours a day, 7 days a week.	W 355		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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W 368	Continued From page 88 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to administer medications as ordered for one of six Sample Clients (Client #6). This failure resulted in the Client receiving the medication in a manner that could make it ineffective. Findings included ... Observation at Apple Cottage on 08/20/19 at 8:35 AM showed Staff J, Licensed Practical Nurse, prepared Client #6's medications prior to administration. As Staff J prepared Client #6's medication, the state surveyor reviewed the medications to ensure the right medication, at the right dose, in the right form, and at the right time, was administered to the right Client. Record review of Client #6's physician orders for medication, dated 07/10/19, showed Client #6 had a diagnosis of constipation and was ordered: -Milk of magnesia triple strength 10 milliliters. As Staff J measured the Milk of magnesia this surveyor identified that the bottle of medication contained a prominent label "Shake well. Do not dilute." Staff J poured the medication into a glass that contained another liquid medication. Staff J later added another medication to the same glass and approximately 2 ounces of water to total approximately 4 ounces.	W 368		

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W 368	Continued From page 89 -Polyethylene glycol (PEG) 17 grams, with the instructions to mix it in the Client's coffee at breakfast. Staff J poured the polyethylene glycol powder into same glass that held the milk of magnesia and another liquid medication. Staff J did not add it to the Clients coffee as ordered by the physician. The glass contained two other medications and approximately 2 ounces of water Staff J added a small amount of applesauce and approximately 2 ounces of water to make approximately 4 ounces. After handing the glass to Client #6, the Client drank approximately half, and then poured the rest of the medication mixture into a glass of juice. Review of Client #6's file showed he had severe, chronic constipation. Record review of Client #6's Annual Nursing Exam Assessment, dated 06/12/19, showed Client #6 became agitated when constipated. During an interview on 08/27/19 at 8:55 AM, Staff N, Clinical Pharmacist, stated that staff should not dilute the milk of magnesia prior to administration and the polyethylene glycol should be given in 6-8 ounces of fluid.	W 368		
W 407	CLIENT LIVING ENVIRONMENT CFR(s): 483.470(a)(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.	W 407		

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W 407	Continued From page 90 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to document why Clients of significantly different ages, functional levels, and social needs all resided in the same house for one of six Sample Clients (Client #3). This failure caused these Clients to live together without any justification, or explanation of the benefits of the living arrangement. Findings included .... Observation on 08/19/19 at 1:40 PM at Pinewood Cottage showed Clients of different ages (30s to 60s), different functional levels, some who walked, some in wheelchairs, some who communicated verbally, and some that did not use speech to communicate. Record review of Client #3's Individual Habilitation Plan, dated 08/13/19, showed no information about how Client #3 could benefit from living with other Clients of significantly different ages, function levels, and social needs. During an interview on 08/27/19 at 4:30 PM, Staff FF, Program Area Team Director, and Staff U, Attendant Counselor Manager, stated that the living arrangements on Pinewood had not been purposefully arranged. They stated that none of the Clients on that cottage had assessments or documentation regarding the differences between them and the benefits of living there.	W 407		
W 423	STORAGE SPACE IN BEDROOMS CFR(s): 483.470(c)(2)	W 423		

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W 423	Continued From page 91 The facility must provide suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a suitable amount of storage space and accessibility for one of six Sample Client's (Client #3) personal possessions. This failure put Client #3's possessions at risk of being stolen or inaccessible to the Client. Findings included ... Observation on 08/19/19 at 1:55 PM at Pinewood Cottage showed Client #3 (male) had a dresser with his personal clothing in Client #7's (female) bedroom. During an interview on 09/21/19 at 9:00 AM, Staff V, Qualified Intellectual Disability Professional, stated that Client #3 did not have sufficient space to put the additional dresser in his room. He stated that if Client #7 required personal privacy in her room then Client #3 would not be able to access his clothing.	W 423		
W 426	CLIENT BATHROOMS CFR(s): 483.470(d)(3) The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.	W 426		

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W 426	Continued From page 92 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure ten locations had water temperatures that didn't exceed 110 degrees Fahrenheit (F). This failure placed Clients at risk for burns. Findings included... 1. Observation on 08/27/19 at 12:09 PM at Bigfoot Cottage showed the 94 side kitchen sink was 114.7 degrees F and the left sink in the back bathroom area was 114.9 degrees F. The 95 side kitchen sink was 118.8 degrees F and the left sink in the back bathroom area was 118.8 degrees F. During an interview on 08/27/19 at 12:09 PM, Staff EE, Attendant Counselor 3, stated that her thermometer had a similar reading as the State Surveyor's. 2. Observation on 08/28/19 starting at 9:15 AM in the gymnasium showed: a. The right sink in the Clients' men's gymnasium bathroom had a temperature of 117.5 degrees F. b. The right sink in the Clients' women's bathroom had a temperature of 116.5 degrees F. c. The exercise room sink used by Clients had a temperature of 117.3 degrees F. d. The game room sink used by Clients had a temperature of 111.8 degrees F.	W 426		

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W 426	Continued From page 93 3. Observations on 08/27/19 starting at 1:30 PM in the Adult training areas used by Clients showed: a. The Ceramic's room sink had a temperature of 122.7 degrees F. b. Training Room #4 had a bathroom sink with a temperature of 121.9 degrees F. c. Training Room #7 had a bathroom sink with a temperature of 125.7 degrees F. 4. Observations on 08/28/19 starting at 9:10 AM in the training area used by Clients showed: a. The Print shop had a bathroom sink with a temperature of 121.2 degrees F. b. The Stars room had a bathroom sink with a temperature of 118 degrees F. During an interview on 08/28/19 at 11:34 AM, Staff T, RHC Facility Services Administrator, stated that water temperatures at the facility were monitored by a service provider located off site. If the facility identified a water temperature that appeared too hot a work order was submitted to have it adjusted.	W 426		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.	W 436		

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	50G007	A. BUILDING _____ B. WING _____	R 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436	Continued From page 94 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide training for communication aides for one of six Sample Clients (Client #3). This failure resulted in Client #3 losing the communication aide as a resource. Findings included ... Record review of Client #3's Individual Habilitation Plan, dated 08/13/19, showed Client #3 had a need in communication and required an assistive communication system. Record review of a Requested Evaluation, dated 04/23/19, for Client #3 in Adult Programs showed Client #3 had shown decreased interest in using his iPad for communication purposes, and instead wanted to use to watch videos. Client #3 was intent on finding YouTube on the device and would ask staff to find YouTube for him. YouTube was removed from his iPad, so Client #3 tried to use other Clients' iPads to access YouTube. The Interdisciplinary Team believed the iPad was a distraction and asked for Client #3 to be moved to a room without iPads. During an interview on 08/21/19 at 9:00 AM, Staff V, Qualified Intellectual Disability Professional, stated that Client #3 did not have a program to teach him to use his iPad for communication.	W 436		
W 456	INFECTION CONTROL CFR(s): 483.470(l)(2) The facility must implement successful corrective	W 456		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50G007	A. BUILDING _____ B. WING _____	R 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND VILLAGE	S 2320 SALNAVE RD, PO BOX 200 MEDICAL LAKE, WA 99022

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W 456	Continued From page 95 action in affected problem areas. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have an active infection prevention program for all Clients at the facility. This failure placed Clients at risk for communicable diseases, and prevented the facility from identifying sources of infection, implementing corrective measures related to cross contamination, and follow up to ensure measures corrected the concern. Findings included ... Record review of an in-service sheet related to infection control and prevention of contamination, dated 08/02/19, showed Client #8 was diagnosed with a bladder infection with the same E-coli Multiple Drug Resistant Organism as Client #2, a housemate. Record review of the facility's policy, "IC [Infection Control] 1.6 SURVEILLANCE FOR HEALTHCARE ACQUIRED INFECTIONS (Facility Acquired)," showed the Infection Control Practitioner was responsible for developing a monthly report to identify facility-acquired infections, which may show patterns of infection, indicating poor infection control practices. The policy identified an outbreak of infection as two or more cases of the same infection in the same cottage. Review of the facility's infection control records showed August 2018 as the last report completed to identify patterns, to analyze interventions, and identify resolution of outbreaks.	W 456		

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W 456	Continued From page 96 During an interview on 08/28/19 at 11:01 AM, Staff LL, Registered Nurse Infection Control Practitioner, stated that there were no current reports or on-going formal review of infections at the facility.	W 456		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure two of six Sample Clients (Clients #4 and #5) received food in a texture appropriate for their developmental level. This failure resulted in an incorrect texture provided for Client #4, and Client #5 received food in a texture for which there was no assessment, no due process, and no justification. Findings included ... Client #4 Record review of a Nutrition Assessment, dated 01/15/19, showed Client #4 was to have a, "Dysphagia Mechanically Altered diet. Moisten all foods with broth or other low calorie liquid, and slurry bread products. No hot dogs or Polish sausage. She drank thin liquids." During an interview on 08/28/19 at 9:41 AM, Staff CC, Speech Pathologist, stated that a Dysphagia Mechanically Altered texture is chopped small about the size of pico de gallo, not pureed. She stated that there was a problem with the kitchen over-texturizing.	W 474		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 474	Continued From page 97 Observation on 08/26/19 from 11:38 AM to 12:10 PM at Evergreen Cottage showed Client #4 ate pureed macaroni-n-cheese, pureed peas, and pureed apricots along with yogurt. Client #5 Review of Client #5's Individual Habilitation Plan, updated 08/12/19, showed his diet texture was "dysphagia advanced." Review of Client #5's file showed no assessment that justified the need for an altered texture diet. During an interview on 08/19/19 at 2:20 PM, Staff GG, Speech Language Pathologist, stated that there was not an assessment in Client #5's file related to his need for an altered texture diet.	W 474		

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RECEIVED
NOV 18 2019
Residential Care Services
ICF/IID Program

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DEVELOPMENTAL DISABILITIES ADMINISTRATION B32-25
Lakeland Village, S. 2320 Salnave Rd.
Mail: P.O. Box 200, Medical Lake, WA 99022-0200
(509) 299-1800 FAX: (509) 299-1070

Gerald Heilinger, Field Manager
ICF/IID Survey and Certification Program
Division of Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

RE: Recertification Revisit Survey from 8/19/2019 through 8/29/2019

ASPEN Event ID: X9V712

Dear Mr. Heilinger:

Enclosed you will find the following documents:

1.) Original 2567 for the Statement of Deficiency
2.) Plan of Correction addressing the specific concerns addressing the key area of "Explaining the process that lead to the deficiency". The Plan of Correction should provide more information as to specific causes.

Sincerely,

Connie Lambert-Eckel
Superintendent
Lakeland Village

This document was prepared by Residential Care Services for the Locator website.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{W 000}	INITIAL COMMENTS This report is the result of a revisit survey to the 06/10/14 through 06/14/19 Recertification Survey at Lakeland Village. The revisit survey occurred on 08/19/19, 08/20/19, 08/21/19, 08/22/19, 08/23/19, 08/26/19, 08/27/19, 08/28/19, and 08/29/19. A sample of six Clients was selected from a census of 97. Three expanded sample Clients were added. The revisit survey occurred in response to a letter from Lakeland Village alleging they were in compliance with the Conditions of Participation found to be non-compliant from the Recertification Survey. During the revisit, an Immediate Jeopardy was identified on 08/21/19 and the revisit survey was extended into a full survey and all Conditions of Participation were reviewed. Lakeland Village submitted a plan to remove the Immediate Jeopardy on 08/22/19. The Survey Team removed the Immediate Jeopardy on 08/28/19. The revisit survey found repeat and new deficiencies. The facility remained out of compliance.. The survey was conducted by: Gerald Heilinger Jim Tarr Patrice Perry Arika Brasier Justin Smith Olivia St. Claire	{W 000}	POC ON SEPARATE DOCUMENT RECEIVED NOV 18 2019 Residential Care Services ICF/IID Program	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

9-26-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This document was prepared by Residential Care Services for the Locator website.

Intermediate Care Facility: Lakeland Village
POC for SOD Date 8/29/2019 and Aspen Event ID# X9V712

RECEIVED
NOV 18 2019
Residential Care Services
ICF/IID Program

Tag number
W102

CFR and title
§483.410 GOVERNING BODY

Specific language from CFR
The facility must ensure that specific governing body and management requirements are met.

Explain the process that lead to this deficiency.
In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The plan correcting the specific deficiency.
See Plan of Correction for W195 and W318 for more detail.

Lakeland Village has contracted with Westcare Management to provide additional root cause analysis, system review, and develop a structured system to meet regulatory standards. Westcare began these collaborative efforts on September 17th, 2019. Lakeland Village and Westcare have established a "task force" that is representative of the different disciplines who compose the interdisciplinary teams to conduct root cause analysis, system review and develop new systems to more effectively meet resident needs.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.
See Plan of Correction for W195 and W318 for more detail.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
Lakeland Village will develop an ICF Quality Assurance and Process Improvement Committee. This committee will consist of membership for staff representation from each department or service area in the ICF. This committee reviews current systems at Lakeland Village, identifies areas for improvement, as well as identifying best practice. Quarterly reports will be provided to the Lakeland Village executive leadership team for review and determination of additional support needed.

The title of the person or persons responsible for implementing the acceptable plan of correction
Connie Lambert-Eckel, Superintendent

Dates when the corrective action will be completed.
Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

Superintendent
Title

Connie Lambert-Eckel
Signature

11.18.19
Date

This document was prepared by Residential Care Services for the Locator website.

Tag number

W104

CFR and title

§482.410(a)(1) GOVERNING BODY

Specific language from CFR

The governing body must exercise general policy, budget, and operating direction over the facility.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The need to schedule follow up appointments was tracked by Team Lead RNs on each IDT. This resulted in not everyone being aware of when a follow up appointment needed to be scheduled. There was no facility wide policy to identify the process of tracking follow up appointments.

The process for reviewing, revising, and creating internal work procedures has not been standardized. This has resulted in procedures being reviewed in isolation of regulatory compliance and with long periods between procedural reviews.

The plan correcting the specific deficiency.

1. Client #6 was seen by a cardiologist on 4/8/2019. The cardiologist reviewed the previous year's echocardiogram and assessed Client #6's cardiac health and indicated the "cardiac examination is normal." The cardiologist recommended a repeat echocardiogram in one (1) year. Person(s) Responsible: Mike Ellis, Team Lead Registered Nurse (RN)
   Completed by: 9/20/2019
2. LV Procedure 7.5 "Assessments: IHP" will be updated to include direction on when and how assessments will be filed in the client record. This procedure will include:
   - Assessments submitted to the HPA by the date of the IHP meeting.
   - All assessments will be filed in the residents' record within 30 days of the assessment being finalized.

   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: 11/22/19/2019
3. Lakeland Village IDT members will be trained on updated LV Procedure 7.5 "Assessments: IHP."
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 27th, 2019
4. LV Procedure 8.6 "Medical Appointments" will be updated to include processes to track when clients have required follow up appointments for specialized medical services. This process includes notification of the IDT members, as well as utilizing automated reminders for IDT members to verify follow up appointments are scheduled.
   Person(s) Responsible: Becky Campbell, RN4
   Completed by: 10/4/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Lakeland Village will establish a procedure to outline the roles and responsibilities for internal procedure review, revisions, and creation.
   Person(s) Responsible: ICF Leadership
   Completed by: December 1st, 2019
2. The ICF Core Team will be trained on the newly created procedure and their roles and expectation in meeting this procedure.

This document was prepared by Residential Care Services for the Locator website.

Person(s) Responsible: ICF Leadership
Completed By: December 13th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Lakeland Village's Program Management Team will meet at least monthly to review that newly created procedures and revisions to existing procedures meet regulatory standards and follow internal defined review processes. Any identified deficits or concerns will be reported to the individuals proposing the procedure or revision to be addressed.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W110

CFR and title

§483.410(c)(1) CLIENT RECORDS

Specific language from CFR

The facility must develop and maintain a record keeping system that includes a separate record for each client.

Explain the process that lead to this deficiency.

Lakeland has implemented more efficient means of communication and record storage using electronic means without revising the necessary internal work procedures to clearly define their roles. This has resulted in some client records being stored in an electronic means solely as opposed to being filed in the client's record as required.

The plan correcting the specific deficiency.

1. LV Procedure 6.9 Client Records, will be updated to clearly define the client record, provide guidance for adding or removing items from the record, as well as a recommended schedule for review of the record to verify accuracy. The procedure will also clearly indicate that any digitally stored record is a copy, and IDT members will verify all records stored digitally are also located in the client's record.
   Person(s) Responsible: Cindy Hall, Forms and records Analyst 3.
   Completed by: October 18th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. The Forms and Records Analyst 3 will revise the current record keeping system to develop a more accurate and concise system.
   Person Responsible: Cindy Hall, Forms and Records Analyst 3.
   Completed by: December 13th, 2019
2. Lakeland Village will establish a procedure to outline the roles and responsibilities for internal procedure review, revisions, and creation.
   Person(s) Responsible: ICF Leadership
   Completed by: December 1st, 2019
3. The ICF Core Team will be trained on the newly created procedure and their roles and expectation in meeting this procedure.
   Person(s) Responsible: ICF Leadership
   Completed By: December 13th, 2019

Note: In addition to the identified procedures above, Lakeland Village is aggressively pursuing an electronic records system.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Lakeland Village's Program Management Team will meet at least monthly to review that newly created procedures and revisions to existing procedures meet regulatory standards and follow internal defined review processes. Any identified deficits or concerns will be reported to the individuals proposing the procedure or revision to be addressed.

Facility HPAs and resident IDT members will complete regular reviews of the resident record to verify all required information is present and accurately filed. Any identified deficiency will be immediately corrected.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

This document was prepared by Residential Care Services for the Locator website.

Tag number

W111

CFR and title

§483.410(c)(1) CLIENT RECORDS

Specific language from CFR

The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.

Explain the process that lead to this deficiency.

Lakeland has implemented more efficient means of communication and record storage using electronic means without revising the necessary internal work procedures to clearly define their roles. This has resulted in some client records being stored in an electronic means solely as opposed to being filed in the client's record as required.

Current internal work procedures indicate that annual assessments that indicate a significant change are to be filed within 30 days of the assessment being completed. This procedure also indicates that if there is no significant change identified in the assessment that it will be filed with the annual IHP. This has resulted in the assessments not being filed in a timely manner.

Current work procedures have not been updated to address the growing trend of outside consultants not providing the facility written with full reports the day of a resident's appointment. This has resulted in not defining an internal procedure to ensure the facility has received and subsequently filing this information.

The plan correcting the specific deficiency.

1. Client #6's annual assessments have been filed in the Resident Unit Record (RUR).
   Person Responsible: Julie Driscoll, Habilitation Plan Administrator (HPA)
   Completed by: 8/29/2019
2. Client #6's Cardiology report for 4/8/2019 has been filed in the Resident Unit Record under the "Radiology/ Consultations" tab.
   Person Responsible: Mike Ellis RN Team Lead
   Completed by: 9/19/2019
3. Client #8's urine culture results have been filed in the Resident Unit Record under the Laboratory (Lab) Results tab.
   Person Responsible: Kathy Evenson RN Team Lead
   Completed by: 8/22/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. LV Procedure 7.5 "Assessments: IHP" will be updated to include direction on when and how assessments will be filed in the client record. This procedure will include:
   - Assessments submitted to the HPA by the date of the IHP meeting.
   - All assessments will be filed in the residents' record within 30 days of the assessment being finalized.

   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: 11/22/19/2019
2. Lakeland Village IDT members will be trained on updated LV Procedure 7.5 "Assessments: IHP."
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 27th, 2019

This document was prepared by Residential Care Services for the Locator website.

3. LV Procedure 8.6 "Medical Appointments" will be updated to include a process for obtaining a full report of a medical appointment and who is responsible for verifying the full report is filed in the RUR.
   Person(s) Responsible: Becky Campbell, RN4
   Completed by: 10/4/2019
4. LV Nursing Procedure 9.1 "Laboratory: Reporting process of," will be updated to identify who is responsible to obtain and file clients' diagnostic test results in the Resident Unit Record (RUR).
   Person(s) Responsible: Becky Campbell, RN4
   Completed by: 10/4/2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs and resident IDT members will complete regular reviews of the resident record to verify all required information is present and accurately filed. Any identified deficiency will be immediately corrected.

The Quality Assurance Department will complete regular reviews of the resident records to verify all required information is present and accurately filed. Any identified deficiency will be immediately reported to the residents IDT for resolution. Quality Assurance will report common trends, both deficits and best practices, identified to ICF leadership.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W124

CFR and title

§483.420(a)(2) PROTECTION OF CLIENT RIGHTS

Specific language from CFR

The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment and the right to refuse treatment.

Explain the process that lead to this deficiency.

The facility has not historically considered medical interventions or treatments and the resident's right to refuse treatment to be restrictive. This resulted in Client #2 receiving medical treatments and interventions without due process.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The plan correcting the specific deficiency.

1. Client #2's soft sleeve with Velcro closure for upper arm stabilization, compression hose, elevated hospital bed, shower chair and a high-sided dish for eating will be reviewed by the IDT and Lakeland Village (LV) Form 17-242A, Informed Consent Medical and Adaptive Equipment will be completed.
   Person (s) responsible: Nora McKinney, HPA
   Completed by: 10/4/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. LV Form 17-242A, Informed Consent Medical and Adaptive Equipment has been modified for the IDT's to utilize for Medical and Adaptive Equipment, which includes a justification, risk versus benefit analysis, and guardian signature.
   Person responsible: Tammy Treat Haynes DDA
   Completed by: September 16th, 2019
2. LV Procedure 3.8 "Consent" will be updated to include receiving informed consent for adaptive equipment. The procedure will include the use and process for LV Form 17-242A Informed Consent.
   Person(s) Responsible: Sharlene Gentry, Assistant Superintendent
   Completed by: October 8th, 2019
3. LV ICF Core Team will receive training on the updated LV 3.8 "Consents."
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: October 15th, 2019
4. IDTs will review residents on the ICF to verify that informed consent has been obtained for all adaptive equipment. The IDT will obtain informed consent for any identified deficit.
   Person(s) Responsible: Facility HPAs
   Completed by: 11/8/2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. The QA Department will complete a review of all residents on the ICF and verify that informed consent was obtained for all adaptive equipment by December 31st, 2019. All identified deficits will be reported to the resident's IDT. If substantial compliance is evident, the QA Department will complete regular reviews in varying frequency to verify compliance is sustained.

This document was prepared by Residential Care Services for the Locator website.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W125

CFR and title

§483.440(a)(3) PROTECTION OF CLIENTS RIGHTS

Specific language from CFR

The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents.

The plan correcting the specific deficiency.

1. Client #3 has been provided his own laundry hamper. The IDT will develop formal programs to assist Client #3 to more independently care for his laundry.
   Person Responsible: Ben Johnson, HPA
   Completed by: 9/27/2019
2. Direct care staff who support Client #3 will receive training on providing him the necessary support and time to make his own choices throughout the day.
   Person Responsible: Ben Johnson, HPA
   Completed by: October 15th, 2019
3. Client #3's dresser has been moved into his own bedroom.
   Person Responsible: Ben Johnson, HPA
   Completed by: September 26th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Lakeland Village has established two additional Habilitation Plan Administrator positions to establish smaller caseloads and improved effectiveness.
   Person(s) Responsible: Tammy Haynes, DDA
   Completed by: 9/18/2019
2. Interviews with qualified HPA candidates will occur on October 9th and 10th.
   Person(s) Responsible: Lorraine McConahy, DDA; Renee Schuiteman, DDA
   Completed by: 10/10/19
3. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the DDA's will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Lorraine McConahy, DDA, Renee Schuiteman, DDA
   Completed by: October 18th, 2019
4. Facility HPAs' office will be relocated to the resident living units to promote more effective and efficient monitoring of supports and training to verify the IDT is meeting the resident's identified needs as well as not violating resident rights. Seventy percent of the HPAs have been relocated to the resident living unit as of November 14th, 2019.
   Person(s) Responsible: Teri Gilden, ICF PAT Director

This document was prepared by Residential Care Services for the Locator website.

Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W126

CFR and title

§483.440(a)(4) PROTECTION OF CLIENT RIGHTS

Specific language from CFR

The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents.

HPAs do not submit completed IHPs to a supervisor or a peer for review prior to implementation. This has resulted in a lack of oversight for regulatory required information and programing being present in an IHP.

The plan correcting the specific deficiency.

1. The IDT reviewed the comprehensive functional assessment for Client #2. A money management program was developed, direct care staff were trained and the program was implemented.
   Person(s) Responsible: Nora McKinney HPA
   Completed: 9/18/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will review all ICF residents' CFAs to verify required money management programs are implemented. For any identified deficit, the HPA will facilitate the resident's IDT to develop necessary programs.
   Person(s) Responsible: Facility HPAs
   Completed by: 12/31/2019
2. Lakeland Village has established two additional Habilitation Plan Administrator positions to establish smaller caseloads and improved effectiveness.
   Person(s) Responsible: Tammy Haynes, DDA
   Completed by: 9/18/2019
3. Interviews with qualified HPA candidates will occur on October 9th and 10th.
   Person(s) Responsible: Lorraine McConahy, DDA; Renee Schuiteman, DDA
   Completed by: 10/10/19
4. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the DDA's will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Lorraine McConahy, DDA, Renee Schuiteman DDA
   Completed by: October 18th, 2019
5. Facility HPAs' office will be relocated to the resident living units to promote more effective and efficient monitoring of supports and training to verify the IDT is meeting the resident's identified needs as well as not violating resident rights. Seventy percent of the HPAs have been relocated to the resident living unit as of November 14th, 2019.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: December 31st, 2019

This document was prepared by Residential Care Services for the Locator website.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W153

CFR and title

§483.420(d)(2) STAFF TREATMENT OF CLIENTS

Specific language from CFR

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

Explain the process that lead to this deficiency.

In response to past citations Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The staff who observed and documented the identified injury identified a likely cause of the injury through observed resident behavior. This resulted in staff not reporting the injury or behavior to appropriate disciplines for further investigation into the function of the behavior as well as establishing any prevention and monitoring strategies.

Staff were not aware of the overall intent of Lakeland Village Procedure 7.8 "Requested Evaluations." This resulted in staff not being aware of the formal process in place for any staff supporting a resident to reporting specific concerns to professional program staff members of the IDT. By not following this procedure, an identified concern of a newly observed behavior was not addressed timely.

The plan correcting the specific deficiency.

1. Client #6's Psychology Associate will complete an assessment to determine the function of the identified behavior.
   Person(s) Responsible: Rikki Miller, Psychology Associate
   Completed by: October 18th, 2019
2. Client #6's IDT will review the Psychology Associates recommendations from the assessment and develop necessary supports.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 25th, 2019
3. Client #6's Chronic Care Plan "Potential Alteration in Skin Integrity related to dry skin and tissue damage from SIB" has been updated to include chronic discoloration around his nipples due to history of self-stimulation of these areas.
   Person Responsible: Mike Ellis RN Team Lead
   Completed by: September 16th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. A directive was sent to all Lakeland Village facility staff to provide clear expectations to thoroughly investigate all injuries of unknown origin or source. Investigations will identify appropriate prevention plans and monitoring of injuries.
   Person Responsible(s): Sharlene Gentry, Assistant Superintendent
   Completed by: 9/25/2019
2. All Lakeland Village staff will receive training on immediately reporting any injury to nursing staff using the See and Tell process. Nursing staff will assess all resident injuries and initiate acute nursing care plans, if indicated.
   Person(s) Responsible: Area Supervisors
   Completed by: 11/1/2019

This document was prepared by Residential Care Services for the Locator website.

3. ICF employees will receive additional training on LV Procedure 7.8 "Requested Evaluations."
   Person(s) Responsible: Area Supervisors
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Team Lead RNs review and analyze acute nursing care plans, including those for injuries, quarterly. Any identified trends or patterns are immediately reported to the resident IDT to develop appropriate modifications and preventative measures.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify current supports provided are meeting resident needs. HPAs will request any additional evaluations necessary and schedule necessary IDT meetings to address the concerns identified.

The title of the person or persons responsible for implementing the acceptable plan of correction

Rebecca Campbell, RN4

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W159

CFR and title

§483.430(a) QIDP

Specific language from CFR

Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents.

The plan correcting the specific deficiency.

1. HPAs will verify each resident has a complete IHP document located in the RUR. Any partial IHP revisions or updates identified will be re-printed to include the entire IHP document.
   Person(s) Responsible: Facility HPAs
   Completed by: 10/11/2019
2. IDT will meet to review Client #2's assessments and develop formal programs to meet his assessed needs.
   Person(s) Responsible: 86/87 Cascade IDT
   Completed by: 10/4/2019
3. The IDT reviewed the comprehensive functional assessment for Client #2. A money management program was developed, direct care staff were trained and the program was implemented.
   Person(s) Responsible: Nora McKinney HPA
   Completed: 9/18/2019
4. IDT for Client #2 will develop additional formal programming based on assessment review to support improving mental stability and increase independence in activities of daily living.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 10/11/2019
5. Direct care staff who work with Client #2 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Nora McKinney, HPA; Angela Moseanko, ACM
   Completed by: October 18th, 2019
6. The IDT met to discuss a plan for Client #3 to wear his orthotics. Two programs were developed to increase Client #3's cooperation by putting his shoes on with orthotics and participating in Physical Therapy 2 to 3 times per week.
   Person Responsible: Ben Johnson, HPA
   Completed by: 8/23/2019
7. An IDT met and a Request for Appointment was submitted to refer Client #3 to an Orthopedic Specialist.

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Person Responsible: Ben Johnson, HPA
Completed by: 8/23/2019

8. Client #3 was referred to an Orthopedic Specialist, Schucker PA-C, to evaluate his custom orthotics. Client # 3's appointment occurred on 9/11/2019. "Recommendation was to discontinue the use of any orthotics or bracing of the feet or ankles secondary to the patient's deformity". The IDT met and agreed with the recommendations of the Orthopedic Specialist to discontinue the custom orthotics and programs associated with that assistive device to aid with walking.
   Person Responsible: Ben Johnson HPA
   Completion date: September 16th, 2019
9. Client #3's programs that were developed to increase his cooperation by putting on his shoes with custom shoe inserts (orthotics) and walking to the PT Department 2-3 times a week were discontinued based on the recommendation of the orthopedic specialist.
   Person responsible: Ben Johnson HPA
   Completion date: September 16th, 2019
10. Client #4's IDT will meet to review her assessments and develop additional formal programs to meet her assessed needs.
    Person(s) Responsible: Evergreen IDT
    Completed by: 10/4/2019
11. Direct Care staff who work with Client #4 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Nora McKinney, HPA; Raleigh Stowe, ACM
    Completed by: October 18th, 2019
12. Client #4's HPA will facilitate a follow up observation of Client #4's day to verify formal programs are meeting her assessed need and will verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Nora McKinney, HPA
    Completed by: 10/31/2019
13. Adult Programs will complete a Comprehensive Vocational Skills Assessment for Client #5.
    Person(s) Responsible: John Borneman, Adult Programs Supervisor
    Completed by: 10/11/2019
14. The IDT will review Client #5's Comprehensive Vocational Skills Assessment and develop necessary supports and training programs to meet his needs. Client's IHP will be updated as indicated by IDT's discussion.
    Person(s) Responsible: Brittany Flores, HPA
    Completed by: October 25th, 2019
15. Client #5's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs.
    Person(s) Responsible: Bigfoot IDT
    Completed by: 10/4/2019
16. Direct Care staff who work with Client #5 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Brittany Flores, HPA; Angela Fabrizio, ACM
17. Client #5's HPA will facilitate a follow up observation of Client #5's day to verify formal programming is meeting his assessed need and will verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.

This document was prepared by Residential Care Services for the Locator website.

Person(s) Responsible: Brittany Flores, HPA
Completed by: 10/31/2019

18. Client #6's HPA will facilitate a review of his CFA and reconcile any discrepancies identified.
Person(s) Responsible: Julie Driscoll, HPA
Completed by: October 18th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Lakeland Village has established two additional Habilitation Plan Administrator positions to establish smaller caseloads and improved effectiveness.
Person(s) Responsible: Tammy Haynes, DDA
Completed by: 9/18/2019
2. Interviews with qualified HPA candidates will occur on October 9th and 10th.
Person(s) Responsible: Lorraine McConahy, DDA; Renee Schuiteman, DDA
Completed by: 10/10/19
3. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the DDA's will work with DSHS Talent Management to reopen the recruitment notice.
Person(s) Responsible: Lorraine McConahy, DDA, Renee Schuiteman DDA
Completed by: October 18th, 2019
4. Facility HPAs' office will be relocated to the resident living units to promote more effective and efficient monitoring of supports and training to verify the IDT is meeting the resident's identified needs as well as not violating resident rights. Seventy percent of the HPAs have been relocated to the resident living unit as of November 14th, 2019.
Person(s) Responsible: Teri Gilden, ICF PAT Director
Completed by: December 31st, 2019
5. HPAs have received training on the role and regulatory responsibilities of a QIDP.
Person(s) Responsible: Westcare Management
Completed by: October 12th, 2019
6. HPAs have received direction to conduct direct data analysis of resident programming. This expectation includes analyzing program data from all resident training programs, regardless of setting.
Person(s) Responsible: Brendan Arkoosh, QAD
Completed by: October 15th, 2019
7. HPAs have received additional training on how to conduct data analysis of resident programming.
Person(s) Responsible: Wayne Altig, QA
Completed by: October 31st, 2019
8. HPAs have received a directive to be present on the living unit conducting frequent observations and monitoring to verify the residents' needs are met, active treatment is occurring, and health care needs are met.
Person(s) Responsible: Lorraine McConahy, DDA; Renee Schuiteman, DDA
Completed by: November 18th, 2019
9. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need.
Person(s) Responsible: Facility HPAs
Completed by: November 22nd, 2019
10. Westcare consultants will sit in on the IDT meetings scheduled to between November 4th thru the 22nd. Consultants will help facilitate where needed as well as provide ongoing coaching, training, and mentoring of HPAs directly after the meetings to help verify the resident needs identified are accurately captured and addressed.
Person(s) Responsible: Westcare Management

This document was prepared by Residential Care Services for the Locator website.

Completed by: Initiated on November 4th, 2019 and ongoing through December of 2019

11. HPAs will receive additional training on writing objectives and formal programs.
    Person(s) Responsible: Westcare Management
    Completed by: December 4th, 2019.
12. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
    Person(s) Responsible: Facility HPAs
    Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W166

CFR and title

§483.430(b)(1) PROFESSIONAL PROGRAM SERVICES

Specific language from CFR

Professional program staff must work with paraprofessional, nonprofessional and other professional program staff who work with clients.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

IDT members did not fully understand their regulatory obligation and how each member's contribution complimented other disciplines to create a comprehensive individual program plan that met the needs of the residents. This resulted in IDT members not fully participating in IDT meetings for residents, not understanding how the content of other discipline's assessments and recommendations could affect their own, and a lack of collaboration on program development for the individual. This resulted in needs being addressed in isolation of a collaborative IDT approach.

Staff were not aware of the overall intent of Lakeland Village Procedure 7.8 "Requested Evaluations." This resulted in staff not being aware of the formal process in place for any staff supporting a resident to reporting specific concerns to professional program staff members of the IDT. By not following this procedure, an identified concern that the current supports for Client #2's were not meeting his need was not addressed timely.

The plan correcting the specific deficiency.

1. The Physical Therapist completed an evaluation to assess Client #2's wheelchair and the possibility of core muscle strengthening exercises, and short distance ambulation.
   Person Responsible: Jered Pettey, Physical Therapist
   Completion date: 8/29/2019
2. The Physical Therapist developed a core-strengthening program for Client #2 to improve posture in the seated position. The Physical Therapy Department provided training for direct care staff on implementing the program.
   Person Responsible: Jered Pettey, Physical Therapist
   Completion date: 8/30/2019
3. The Physical Therapy Department and Inland Medical and Rehab completed an assessment on Client #2's wheelchair. A new custom fitted wheelchair has been ordered for Client #2.
   Person Responsible: Jered Pettey, Physical Therapist
   Completion date: 8/29/2019
4. The Physical Therapist developed a program for Client #2 to participate in exercises, standing or ambulation for eight (8) weeks. The Physical Therapy department trained direct care staff on this program.
   Person Responsible: Jered Pettey, Physical Therapist
   Completion date: 9/13/2019
5. The Physical Therapist developed a physical therapy program for Client #2 to participate in formal physical therapy two (2) times per week for strengthening for eight (8) weeks. The Physical Therapist will evaluate Client #2's progress and make recommendations to the IDT for modifications or continuation of the program.
   Person Responsible: Jered Pettey, Physical Therapist

This document was prepared by Residential Care Services for the Locator website.

Completion date: 8/30/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

4. LV Procedure 8.6 "Medical Appointments" has been updated to include a process for medical appointments and consultant's recommendation. This process includes:
   - **a.** IDT process for scheduling a medical appointment
   - **b.** Development of any necessary pre-appointment care plans;
   - **c.** Facilitation of IDT discussion on the results of the appointment, including the IDT's decision with regards to the consultant's recommendation and the IDTs plan to meet the resident's identified need; and
   - **d.** Development and implementation of all necessary post appointment care plans, revisions or updates to the resident's IHP.

   Person(s) Responsible: Brendan Arkoosh QAD
   Completed by: August 28th, 2019
5. LV Form 30-101A "IDT Appointment Follow-up" has been implemented to document the outcome of a resident's appointment and the IDT's plan.
   Person Responsible: Brendan Arkoosh
   Completed by: August 28th, 2019
6. ICF employees will receive additional training on LV Procedure 7.8 "Requested Evaluations."
   Person(s) Responsible: Area Supervisors
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify current supports provided are meeting resident needs. HPAs will request any additional evaluations necessary and schedule necessary IDT meetings to address the concerns identified.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W185

CFR and title

§483.430(c)(4) FACILITY STAFFING

Specific language from CFR

The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

All ICF employees did not have a thorough understanding of how the regulations work together to require a comprehensive system of supports and service to meet the resident needs. This resulted in individuals understanding singular and sometimes clusters of regulations in isolation of the overall intent of all the regulations together. This has resulted in IDT members not having a clear understanding of the overall intent of meeting residents identified needs in hopes of moving to a less restrictive environment.

The plan correcting the specific deficiency.

1. Cleaning duties will be removed from the Post-Schedules and Daily Assignment Sheets during resident waking hours.
   Person(s) Responsible: Facility ACMs
   Completed by: October 8th, 2019
2. Direct Care Staff received direction concerning assisting residents, through formal or informal opportunities, to maintain their own environments to the extent possible.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: 9/25/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. IDT members responsible for completing resident assessments will review current assessments to verify they accurately identify the residents needs and meet regulatory requirements of the CFA.
   Person(s) Responsible: IDT Members
   Completed by: November 4th, 2019
2. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
3. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019
4. Lakeland Village has modified the current Active Treatment Schedule (ATS) to more clearly identify the formal training programs, informal objectives, and the skills to be maintained for each resident. This schedule also more clearly identifies when each of these training opportunities is likely to occur for the residents.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019

This document was prepared by Residential Care Services for the Locator website.

5. All resident ATS will be updated to the new format and include any new training programs, informal objective or skills to be maintained identified from the updated IHP meetings.
   Person(s) Responsible: ACMs
   Completed by: December 31st, 2019
6. All ICF employees will receive additional training on the regulatory requirements of active treatment. Including how resident choice and self-management are essential components of active treatment.
   Person(s) Responsible: Westcare Management, LV Staff Development
   Completed by: January 31st, 2020

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W195

CFR and title

§483.440 ACTIVE TREATMENT SERVICES

Specific language from CFR

The facility must ensure that specific active treatment services requirements are met.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

All ICF employees did not have a thorough understanding of how the regulations work together to require a comprehensive system of supports and service to meet the resident needs. This resulted in individuals understanding singular and sometimes clusters of regulations in isolation of the overall intent of all the regulations together. This has resulted in IDT members not having a clear understanding of the overall intent of meeting residents identified needs in hopes of moving to a less restrictive environment.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify resident needs were being met and that continuous and aggressive active treatment was occurring. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents

The ICF DDA had a supervisory span of control that hindered effective and efficient oversight of the HPAs. This hindered ability to review and provide ongoing feedback on individual work performance and regulatory compliance. When systematic changes occurred, it was also not possible to complete thorough reviews of HPAs work to verify compliance with system changes and provide immediate feedback.

The plan correcting the specific deficiency.

1. The IDT for Client #1 will meet to review Client #1's assessed needs. The IDT will review Client #1's Primary Need and make necessary revisions based on Client #1's assessed needs.
   Person(s) Responsible: Hillside IDT
   Complete by: 10/4/2019
2. The IDT for Client #1 will develop additional formal programs to increase his independence in activities of daily living.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/11/2019
3. Direct care staff who work with Client #1 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Jana McCluskey, HPA; Brian-Keith Jennings, ACM
   Completed by: October 18th, 2019
4. Current formal programs for Client #1 will be reviewed to verify special training considerations for moderate to severe hearing loss are included.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/1/2019
5. Direct care staff who support Client #1 will receive training on providing him the necessary support and time to make his own choices throughout the day.

This document was prepared by Residential Care Services for the Locator website.

Person Responsible: Jana McCluskey, HPA
Completed by: October 15th, 2019

6. IDT will meet to review Client #2's assessments and develop formal programs to meet his assessed needs.
   Person(s) Responsible: 86/87 Cascade IDT
   Completed by: 10/4/2019
7. IDT for Client #2 will develop additional formal programming based on assessment review to support improving mental stability and increase independence in activities of daily living.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 10/11/2019
8. Direct care staff who work with Client #2 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Nora McKinney, HPA; Angela Moseanko, ACM
   Completed by: October 18th, 2019
9. The IDT met to discuss a plan for Client #3 to wear his orthotics. Two programs were developed to increase Client #3's cooperation by putting his shoes on with orthotics and participating in Physical Therapy 2 to 3 times per week.
   Person Responsible: Ben Johnson, HPA
   Completed by: 8/23/2019
10. The IDT met and a Request for Appointment was submitted to refer Client #3 to an Orthopedic Specialist.
    Person Responsible: Ben Johnson, HPA
    Completed by: 8/23/2019
11. Client #3 was referred to an Orthopedic Specialist, Schucker PA-C, to evaluate his custom orthotics. Client # 3's appointment occurred on 9/11/2019. "Recommendation was to discontinue the use of any orthotics or bracing of the feet or ankles secondary to the patient's deformity". The IDT met on, agreed with the recommendations of the Orthopedic Specialist to discontinue the custom orthotics, and associated program.
    Person Responsible: Ben Johnson HPA
    Completion date: September 16th, 2019
12. Client #3's programs that were developed to increase his cooperation by putting on his shoes with custom shoe inserts (orthotics) and walking to the PT Department 2-3 times a week were discontinued based on the recommendation of the orthopedic specialist.
    Person responsible: Ben Johnson HPA
    Completion date: September 16th, 2019
13. Speech Pathologist will update Client #3's Comprehensive Communication Assessment to include, barriers to communication that are present, what services are available and what training/programs are needed to address his communication needs.
    Person Responsible: Beth Budke, Speech Pathologist
    Completion date: 10/4/2019
14. Client #3's Psychology Associate and SLP will conduct a collaborative evaluation to determine distinguishing characteristics of when Client #3 is grasping people's arm to gain their attention versus as a form of aggression. The IDT will develop necessary training programs and support to meet the identified need and function of both intended purposes of Client #3 grasping people's arm.
    Person Responsible: Steve Allen, Psych Associate; Beth Budke, Speech Pathologist; Ben Johnson, HPA
    Completion date: 10/3/2019
15. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to accurately reflect any necessary changes.

This document was prepared by Residential Care Services for the Locator website.

Responsible person: Ben Johnson, HPA
Completed by: 10/4/2019

16. Direct care staff who work with Client #3 will receive training on any new or updated programs as well as any IHP revisions.
    Person(s) Responsible: Ben Johnson HPA
    Completed by: 10/11/2019
17. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to include a formal communication program and to accurately reflect any necessary changes.
    Responsible person: Ben Johnson, HPA
    Completed by: 10/4/2019
18. Direct care staff who support Client #3 will receive training on providing him the necessary support and time to make his own choices throughout the day.
    Person Responsible: Ben Johnson, HPA
    Completed by: October 15th, 2019
19. The identified staff will receive additional training on how to implement Client #3's formal program K.08.
    Person(s) Responsible: Erica Horton, RN3
    Completed by: 10/4/2019
20. Client #4's IDT will meet to review her assessments and develop additional formal programs to meet her assessed needs.
    Person(s) Responsible: Evergreen IDT
    Completed by: 10/4/2019
21. Direct Care staff who work with Client #4 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Nora McKinney, HPA; Raleigh Stowe, ACM
    Completed by: October 18th, 2019
22. Client #4's HPA will facilitate a follow up observation of Client #4's day to verify formal programming is meeting her assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Nora McKinney, HPA
    Completed by: 10/31/2019
23. Client #4's formal programs will be updated to set projected completion dates based on her rate of learning.
    Person(s) Responsible: Nora McKinney, HPA
    Completed By: October 18th, 2019
24. Client #5's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs.
    Person(s) Responsible: Bigfoot IDT
    Completed by: 10/4/2019
25. Direct Care staff who work with Client #5 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Brittany Flores, HPA; Angela Fabrizio, ACM
26. Client #5's HPA will facilitate a follow up observation of Client #5's day to verify formal programming is meeting his assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Brittany Flores, HPA
    Completed by: 10/31/2019

This document was prepared by Residential Care Services for the Locator website.

27. Client #5's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #5's IHP will be updated as required to accurately reflect any necessary changes.
    Responsible person: Brittany Flores, HPA
    Completed by: 10/4/2019
28. Direct care staff who work with Client #5 will receive training on any new or updated programs as well as any IHP revisions.
    Person(s) Responsible: Brittany Flores, HPA
    Completed by: October 18th, 2019
29. Client #6's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs as well as decrease his dependence on cues from direct care staff.
    Person(s) Responsible: Apple IDT
    Completed by: 10/4/2019
30. Direct Care staff who work with Client #6 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Julie Driscoll, HPA; Patty Thomas, ACM
    Completed by: October 18th, 2019
31. Client #6's HPA will facilitate a follow up observation of Client #6's day to verify formal programming is meeting his assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Julie Driscoll, HPA
    Completed by: 10/31/2019
32. Client #6's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs to decrease his dependence on cues, increase independence during meals, and increase intentional communication skills.
    Person(s) Responsible: Apple IDT
    Completed by: 10/4/2019
33. Client #6's formal programs will be updated to set projected completion dates based on his rate of learning.
    Person(s) Responsible: Julie Driscoll, HPA
    Completed by: October 18th, 2019
34. The identified formal programs for Client #6 will be revised to provide clear detailed instructions to staff who implement the programs.
    Person(s) Responsible: Julie Driscoll, HPA
    Completed by: October 18th, 2019
35. HPA will complete follow up observations on the revised programs being implemented to verify the program revisions provide clear detailed instructions and staff are able to accurately follow the teaching instructions.
    Person(s) Responsible: Julie Driscoll, HPA
    Completed by: 10/31/2019
36. Speech Pathologist updated Client #6's Comprehensive Communication Assessment to include what barriers are present, what services are available and what programs and services are recommended to assist Client #6 in meeting his communication needs.
    Person Responsible: Monica Manza, Speech Pathologist
    Completion date: September 23rd, 2019
37. Client #6's IDT will meet to review the updated Comprehensive Communication Assessment and the identified needs and recommendations. The HPA will update the IHP as required based on the assessment and IDT decisions.

This document was prepared by Residential Care Services for the Locator website.

Person(s) Responsible: Julie Driscoll, HPA
Completed by: 10/3/2019

38. Client #6's Psychology Associate will complete an assessment to determine the function of the identified self-injurious behavior.
Person(s) Responsible: Rikki Miller, Psychology Associate
Completed by: October 18th, 2019
39. Client #6's IDT will review the Psychology Associates recommendations from the assessment and develop necessary supports.
Person(s) Responsible: Julie Driscoll, HPA
Completed by: October 25th, 2019
40. The identified staff received additional training on how to implement Client #6's formal program.
Person(s) Responsible: Mike Ellis
Completed by: 9/19/2019
41. HPA will complete follow up observations on the revised programs being implemented to verify the program revisions provide clear detailed instructions and staff are able to accurately follow the teaching instructions.
Person(s) Responsible: Julie Driscoll, HPA
Completed by: 10/31/2019
42. HPAs for the identified residents will review and analyze all program data collected. HPAs will report any concerns to the resident's IDT for collaboration and revisions to verify accurate data is being taken as well as analyzed.
Person(s) Responsible: Facility HPAs
Completed by: October 15th, 2019
43. HPAs have been directed to conduct direct analysis of formal program data. This includes a direct analysis of the program data collection sheet to identify potential trends, areas of concerns, or potential early advancement of the program based on the review and IDT decision.
Person(s) Responsible: Teri Gilden, ICF PAT Director
Completed by: 9/25/2019
44. Lakeland Village Speech Pathologists have reviewed and updated the comprehensive Speech and Language assessment to include speech and language development, Comprehensive Communication Assessment to include what barriers are present, what services are available and what programs and services are recommended to assist meeting resident needs.
Person Responsible: Beth Burke Speech Pathologist
Completion date: September 26th, 2019
45. Direct care staff who support Client #9 will receive training on providing her the necessary support and time to make her own choices throughout the day.
Person Responsible: Jana McCluskey, HPA
Completed by: October 15th, 2019
46. Direct care staff who support Client #9 will receive training on supports versus restrictions and resident rights.
Person(s) Responsible: Staff Development Department
Completed by: October 25th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. See 159 for additional details of the procedure for implementing an acceptable plan of correction concerning Lakeland Village's HPAs, which serve the role of the QIDP.
2. Lakeland Village hired two additional Developmental Disabilities Administrators (DDAs).
Person(s) Responsible: Teri Gilden, ICF PAT Director

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Completed by: October 1st, 2019

3. The DDAs will have a supervisory span of control that includes both Attendant Counselor Managers (ACMs) and HPAs.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: October 15th, 2019
4. IDT members responsible for completing resident assessments will review current assessments to verify they accurately identify the residents' needs and meet regulatory requirements of the CFA.
   Person(s) Responsible: IDT Members
   Completed by: November 4th, 2019
5. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
6. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019
7. Lakeland Village has changed its graduated guidance model (the hierarchy of supports implemented to assist a resident to learn a new skill) to be more intuitive and align with nationally accepted and used standards.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: October, 15th, 2019
8. All Lakeland Village ICF employees will be trained in the new graduated guidance model.
   Person(s) Responsible: Staff Development
   Completed by: December 31st 2019
9. Lakeland Village has modified its Program Description Form (the template used to document instructions of formal programs) to be more intuitive, promote regulatory compliance, and promote consistency of implementation.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019
10. Lakeland Village has modified the current Active Treatment Schedule (ATS) to more clearly identify the formal training programs, informal objectives, and the skills to be maintained for each resident. This schedule also more clearly identifies when each of these training opportunities is likely to occur for the residents.
    Person(s) Responsible: Brendan Arkoosh, QAD
    Completed by: November 20th, 2019
11. All resident ATS will be updated to the new format and include any new training programs, informal objective or skills to be maintained identified from the updated IHP meetings.
    Person(s) Responsible: ACMs
    Completed by: December 31st, 2019
12. All ICF employees will receive additional training on the regulatory requirements of active treatment.
    Person(s) Responsible: Westcare Management, LV Staff Development
    Completed by: January 31st, 2020

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

This document was prepared by Residential Care Services for the Locator website.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct routine Active Treatment Observations to verify training needs are met, active treatment is continuous and aggressive, program implementation is occurring as expected, and resident choice and self-management is promoted. The Quality Assurance Department will provide direct feedback to staff they observe. Any identified deficit will be reported to the HPA and the area supervisor for resolution.

Lakeland Village will develop an ICF Quality Assurance and Process Improvement Committee. This committee will consist of membership for staff representation from each department or service area in the ICF. This committee reviews current systems at Lakeland Village, identifies areas for improvement, as well as identifying best practice. Quarterly reports will be provided to the Lakeland Village executive leadership team for review and determination of additional support needed.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director
Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W196

CFR and title

§483.440 (a)(1) ACTIVE TREATMENT

Specific language from CFR

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:

(i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

All ICF employees did not have a thorough understanding of how the regulations work together to require a comprehensive system of supports and service to meet the resident needs. This resulted in individuals understanding singular and sometimes clusters of regulations in isolation of the overall intent of all the regulations together. This has resulted in IDT members not having a clear understanding of the overall intent of meeting residents identified needs in hopes of moving to a less restrictive environment.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify resident needs were being met and that continuous and aggressive active treatment was occurring. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents

The ICF DDA had a supervisory span of control that hindered effective and efficient oversight of the HPAs. This hindered ability to review and provide ongoing feedback on individual work performance and regulatory compliance. When systematic changes occurred, it was also not possible to complete thorough reviews of HPAs work to verify compliance with system changes and provide immediate feedback.

The plan correcting the specific deficiency.

Client #1

1. The IDT for Client #1 will meet to review Client #1's assessed needs. The IDT will review Client #1's Primary Need and make necessary revisions based on Client #1's assessed needs.
   Person(s) Responsible: Hillside IDT
   Complete by: 10/4/2019
2. The IDT for Client #1 will develop additional formal programs to increase his independence in activities of daily living.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/11/2019
3. Direct care staff who work with Client #1 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Jana McCluskey, HPA; Brian-Keith Jennings, ACM
   Completed by: October 18th, 2019

This document was prepared by Residential Care Services for the Locator website.

4. Current formal programs for Client #1 will be reviewed to verify special training considerations for moderate to severe hearing loss are included.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/1/2019

Client #2

5. IDT will meet to review Client #2's assessments and develop formal programs to meet his assessed needs.
   Person(s) Responsible: 86/87 Cascade IDT
   Completed by: 10/4/2019
6. IDT for Client #2 will develop additional formal programming based on assessment review to support improving mental stability and increase independence in activities of daily living.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 10/11/2019
7. Direct care staff who work with Client #2 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Nora McKinney, HPA; Angela Moseanko, ACM
   Completed by: October 18th, 2019

Client #3

8. The IDT met to discuss a plan for Client #3 to wear his orthotics. Two programs were developed to increase Client #3's cooperation by putting his shoes on with orthotics and participating in Physical Therapy 2 to 3 times per week.
   Person Responsible: Ben Johnson, HPA
   Completed by: 8/23/2019
9. An IDT met and a Request for Appointment was submitted to refer Client #3 to an Orthopedic Specialist.
   Person Responsible: Ben Johnson, HPA
   Completed by: 8/23/2019
10. Client #3 was referred to an Orthopedic Specialist, PA-C Shucker to evaluate his custom orthotics. Client # 3's appointment occurred on 9/11/2019. "Recommendation was to discontinue the use of any orthotics or bracing of the feet or ankles secondary to the patient's deformity". The IDT met on and agreed with the recommendations of the Orthopedic Specialist to discontinue the custom orthotics and programs associated with that assistive device to aid with walking.
    Person Responsible: Ben Johnson HPA
    Completion date: September 16th, 2019
11. Client #3's programs that were developed to increase his cooperation by putting on his shoes with custom shoe inserts (orthotics) and walking to the PT Department 2-3 times a week were discontinued based on the recommendation of the orthopedic specialist.
    Person responsible: Ben Johnson HPA
    Completion date: September 16th, 2019
12. Speech Pathologist will update Client #3's Comprehensive Communication Assessment to include, barriers to communication that are present, what services are available and what training/programs are needed to address his communication needs.
    Person Responsible: Beth Budke, Speech Pathologist
    Completion date: 10/4/2019
13. Client #3's Psychology Associate and SLP will conduct a collaborative evaluation to determine distinguishing characteristics of when Client #3 is grasping people's arm to gain their attention versus as a form of aggression. The IDT will develop necessary training programs and support to meet the identified need and function of both intended purposes of Client #3 grasping people's arm.
    Person Responsible: Steve Allen, Psych Associate; Beth Budke, Speech Pathologist; Ben Johnson, HPA

This document was prepared by Residential Care Services for the Locator website.

Completion date: 10/3/2019

14. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to accurately reflect any necessary changes.
    Responsible person: Ben Johnson, HPA
    Completed by: 10/4/2019
15. Direct care staff who work with Client #3 will receive training on any new or updated programs as well as any IHP revisions.
    Person(s) Responsible: Ben Johnson HPA
    Completed by: 10/11/2019

Client #4

16. Client #4's IDT will meet to review her assessments and develop additional formal programs to meet her assessed needs.
    Person(s) Responsible: Evergreen IDT
    Completed by: 10/4/2019
17. Direct Care staff who work with Client #4 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Nora McKinney, HPA; Raleigh Stowe, ACM
    Completed by: October 18th, 2019
18. Client #4's HPA will facilitate a follow up observation of Client #4's day to verify formal programming is meeting her assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Nora McKinney, HPA
    Completed by: 10/31/2019

Client #5

19. Client #5's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs.
    Person(s) Responsible: Bigfoot IDT
    Completed by: 10/4/2019
20. Direct Care staff who work with Client #5 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Brittany Flores, HPA; Angela Fabrizio, ACM
21. Client #5's HPA will facilitate a follow up observation of Client #5's day to verify formal programming is meeting his assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Brittany Flores, HPA
    Completed by: 10/31/2019

Client #6

22. Client #6's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs as well as decrease his dependence on cues from direct care staff.
    Person(s) Responsible: Apple IDT
    Completed by: 10/4/2019
23. Direct Care staff who work with Client #6 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Julie Driscoll, HPA; Patty Thomas, ACM
    Completed by: October 18th, 2019

This document was prepared by Residential Care Services for the Locator website.

24. Client #6's HPA will facilitate a follow up observation of Client #6's day to verify formal programming is meeting his assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Julie Driscoll, HPA
    Completed by: 10/31/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. See 159 for additional details of the procedure for implementing an acceptable plan of correction concerning Lakeland Village's HPAs, which serve the role of the QIDP.
2. Lakeland Village hired two additional Developmental Disabilities Administrators (DDAs).
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: October 1st, 2019
3. The DDAs will have a supervisory span of control that includes both Attendant Counselor Managers (ACMs) and HPAs.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: October 15th, 2019
4. IDT members responsible for completing resident assessments will review current assessments to verify they accurately identify the residents' needs and meet regulatory requirements of the CFA.
   Person(s) Responsible: IDT Members
   Completed by: November 4th, 2019
5. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
6. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019
7. Lakeland Village has changed its graduated guidance model (the hierarchy of supports implemented to assist a resident to learn a new skill) to be more intuitive and align with nationally accepted and used standards.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: October, 15th, 2019
8. All Lakeland Village ICF employees will be trained in the new graduated guidance model.
   Person(s) Responsible: Staff Development
   Completed by: December 31st 2019
9. Lakeland Village has modified its Program Description Form (the template used to document instructions of formal programs) to be more intuitive, promote regulatory compliance, and promote consistency of implementation.
10. =Person(s) Responsible: Brendan Arkoosh, QAD
    Completed by: November 20th, 2019
11. Lakeland Village has modified the current Active Treatment Schedule (ATS) to more clearly identify the formal training programs, informal objectives, and the skills to be maintained for each resident. This schedule also more clearly identifies when each of these training opportunities is likely to occur for the residents.
    Person(s) Responsible: Brendan Arkoosh, QAD
    Completed by: November 20th, 2019
12. All resident's ATS will be updated to the new format and include any new training programs, informal objective or skills to be maintained identified from the updated IHP meetings.
    Person(s) Responsible: ACMs

This document was prepared by Residential Care Services for the Locator website.

Completed by: December 31st, 2019

13. All ICF employees will receive additional training on the regulatory requirements of active treatment.
    Person(s) Responsible: Westcare Management, LV Staff Development
    Completed by: January 31st, 2020

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training resident needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. Any identified deficits will be addressed by the HPA.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency as sustainable compliance is evident.

Lakeland Village will develop an ICF Quality Assurance and Process Improvement Committee. This committee will consist of membership for staff representation from each department or service area in the ICF. This committee reviews current systems at Lakeland Village, identify areas for improvement, as well as identifying best practice. Quarterly reports will be provided to the Lakeland Village executive leadership team for review and determination of additional support needed.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD
Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W206

CFR and title

§483.440(c)(1) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to:

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

IDT members did not fully understand their regulatory obligation and how each member's contribution complimented other disciplines to create a comprehensive individual program plan that met the needs of the residents. This resulted in IDT members not fully participating in IDT meetings for residents, not understanding how the content of other discipline's assessments and recommendations could affect their own, and a lack of collaboration on program development for the individual. This resulted in needs being addressed in isolation of a collaborative IDT approach.

The plan correcting the specific deficiency.

1. Speech Pathologist will update Client #3's Comprehensive Communication Assessment to include, barriers to communication that are present, what services are available and what training/programs are needed to address his communication needs.
   Person Responsible: Beth Budke, Speech Pathologist
   Completion date: 10/4/2019
2. Client #3's Psychology Associate and SLP will conduct a collaborative evaluation to determine distinguishing characteristics of when Client #3 is grasping people's arm to gain their attention versus as a form of aggression. The IDT will develop necessary training programs and support to meet the identified need and function of both intended purposes of Client #3 grasping people's arm.
   Person Responsible: Steve Allen, Psych Associate; Beth Budke, Speech Pathologist; Ben Johnson, HPA
   Completion date: 10/3/2019
3. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to accurately reflect any necessary changes.
   Responsible person: Ben Johnson, HPA
   Completed by: 10/4/2019
4. Direct care staff who work with Client #3 will receive training on any new or updated programs as well as any IHP revisions.
   Person(s) Responsible: Ben Johnson HPA
   Completed by: 10/11/2019
5. Client #5's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #5's IHP will be updated as required to accurately reflect any necessary changes.
   Responsible person: Brittany Flores, HPA
   Completed by: 10/4/2019

This document was prepared by Residential Care Services for the Locator website.

6. Direct care staff who work with Client #5 will receive training on any new or updated programs as well as any IHP revisions.
   Person(s) Responsible: Brittany Flores, HPA
   Completed by: October 18th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Disciplines responsible for assessing areas of the CFA will review their respective assessments against regulations to verify all required areas are being assessed. Upon completion of this review, all disciplines will collaboratively review all assessment areas of the CFA to verify all required areas identified in regulation are adequately assessed across disciplines to accurately identify each resident's individual needs.
   Person(s) Responsible: Lakeland Village IDT Members
   Completed by: October 15th, 2019
2. All members of the ICF Core team have received training on the regulatory requirements of the IDT. This training included how the IDT functions together, how assessments work together to create the Comprehensive Functional Assessment for the resident, and how the HPA facilitates IDT collaboration in the development of the residents IHP.
   Person(s) Responsible: Westcare Management
   Completed by: October 9th, 2019
3. Staff Development is creating additional IDT training for ICF Core Team members to promote further regulatory understanding of each member's role in supporting the development of the residents IHP and meeting the residents identified needs.
   Person(s) Responsible: Staff Development
   Completed by: December 31st, 2019
4. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
5. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

This document was prepared by Residential Care Services for the Locator website.

Tag number

W214

CFR and title

§483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Psychology Associates were not supervised by a licensed clinical Psychologist. This resulted in Psychology Associates not fully understanding the regulatory requirements around functional behavior assessment. This resulted in assessments that did not adequately assess required areas identified in regulations.

The plan correcting the specific deficiency.

1. Speech Pathologist updated Client #6's Comprehensive Communication Assessment to include what barriers are present, what services are available and what programs and services are recommended to assist Client #6 in meeting his communication needs.
   Person Responsible: Monica Manza, Speech Pathologist
   Completion date: September 23rd, 2019
2. Client #6's IDT will meet to review the update Comprehensive Communication Assessment and the identified needs and recommendations. The HPA will update the IHP as required based on the assessment and IDT decisions.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: 10/3/2019
3. Client #6's Psychology Associate will complete an assessment to determine the function of the identified self-injurious behavior.
   Person(s) Responsible: Rikki Miller, Psychology Associate
   Completed by: October 18th, 2019
4. Client #6's IDT will review the Psychology Associates recommendations from the assessment and develop necessary supports.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 25th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Disciplines responsible for assessing areas of the CFA will review their respective assessments against regulations to verify all required areas are being assessed. Upon completion of this review, all disciplines will collaboratively review all assessment areas of the CFA to verify all required areas identified in regulation are adequately assessed across disciplines to accurately identify each resident's individual needs.
   Person(s) Responsible: Lakeland Village IDT Members
   Completed by: October 15th, 2019
2. See W220 for additional details with regards to Comprehensive Communication Assessment
3. Lakeland Village has hired a licensed clinical Psychologist to supervise the Psychology Associates.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent

This document was prepared by Residential Care Services for the Locator website.

Completed by: October 1st, 2019

4. Psychology Associates will receive initial training on identifying the function of observed maladaptive behaviors.
   Person(s) Responsible: Dr. Jane Schilling, PhD and Westcare Management
   Completed by: December 31st, 2019
5. Psychology Associate will receive ongoing coaching, training, mentoring and support in effectively completing functional behavioral assessments.
   Person(s) Responsible: Dr. Jane Schilling, PhD
6. The Psychology Department will implement a new replacement behavior program-teaching template. This template more clearly identifies the goals and strategies for assisting the resident in learning appropriate replacement behaviors based on the functional behavioral assessment.
   Person(s) Responsible: Dr. Jane Schilling, PhD

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The licensed clinical Psychologist will review all behavior management plans and associated functional behavioral assessments prior to implementation for the next year. Any identified deficits or concerns will be reported back to the Psychology Associate for correction. These reviews will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will complete a 50% review of all full assessments completed in the next 6 months. Any identified deficits in assessing in regulatory required areas will be directly reported to the assigned discipline and their supervisor for correction. The Quality Assurance Department will work with Staff Development and other assigned disciplines in that area to develop focused training on reoccurring deficient areas. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Dr. Jane Schilling, PhD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W218

CFR and title

§483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The comprehensive functional assessment must include sensorimotor development.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Assigned disciplines were not fully aware of the regulatory requirements around their assessment area. Assessment templates were created using professional judgement, knowledge, and experience. This resulted in assessments that did not adequately assess required areas identified in regulations.

The plan correcting the specific deficiency.

1. The IDT met to discuss a plan for Client #3 to wear his orthotics. Two programs were developed to increase Client #3's cooperation by putting his shoes on with orthotics and participating in Physical Therapy 2 to 3 times per week.
   Person Responsible: Ben Johnson, HPA
   Completed by: 8/23/2019
2. An IDT met and a Request for Appointment was submitted to refer Client #3 to an Orthopedic Specialist.
   Person Responsible: Ben Johnson, HPA
   Completed by: 8/23/2019
3. Client #3 was referred to an Orthopedic Specialist, PA-C Shucker to evaluate his custom orthotics. Client # 3's appointment occurred on 9/11/2019. "Recommendation was to discontinue the use of any orthotics or bracing of the feet or ankles secondary to the patient's deformity". The IDT met on and agreed with the recommendations of the Orthopedic Specialist to discontinue the custom orthotics and programs associated with that assistive device to aid with walking.
   Person Responsible: Ben Johnson HPA
   Completion date: September 16th, 2019
4. Client #3's programs that were developed to increase his cooperation by putting on his shoes with custom shoe inserts (orthotics) and walking to the PT Department 2-3 times a week were discontinued based on the recommendation of the orthopedic specialist.
   Person responsible: Ben Johnson HPA
   Completion date: September 16th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Disciplines responsible for assessing areas of the CFA will review their respective assessments against regulations to verify all required areas are being assessed. Upon completion of this review, all disciplines will collaboratively review all assessment areas of the CFA to verify all required areas identified in regulation are adequately assessed across disciplines to accurately identify each resident's individual needs.
   Person(s) Responsible: Lakeland Village IDT Members
   Completed by: October 15th, 2019
2. The Physical Therapy Department received training and guidance on the regulatory requirements around sensorimotor assessments.
   Person(s) Responsible: Westcare Management

This document was prepared by Residential Care Services for the Locator website.

Completed by: October 15th, 2019

3. The Physical Therapy Department will review all current assessments to verify current assessments include sensorimotor development information. Any identified deficit will be corrected and submitted to the resident's HPA.
   Person(s) Responsible: Physical Therapy Department
   Completed by: November 22nd, 2019
4. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
5. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Quality Assurance Department will complete a 50% review of all sensorimotor assessments completed in the next 6 months. Any identified deficits in assessing in regulatory required areas will be directly reported to the assigned discipline and their supervisor for correction. The Quality Assurance Department will work with Staff Development and other assigned disciplines in that area to develop focused training on reoccurring deficient areas. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD
Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W220

CFR and title

§483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The comprehensive functional assessment must include speech and language development.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Assigned disciplines were not fully aware of the regulatory requirements around their assessment area. Assessment templates were created using professional judgement, knowledge, and experience. This resulted in assessments that did not adequately assess required areas identified in regulations.

The plan correcting the specific deficiency.

1. Speech Pathologist updated Client #6's Comprehensive Communication Assessment to include what barriers are present, what services are available and what programs and services are recommended to assist Client #6 in meeting his communication needs.
   Person Responsible: Monica Manza, Speech Pathologist
   Completion date: September 23rd, 2019
2. Client #6's IDT will meet to review the update Comprehensive Communication Assessment and the identified needs and recommendations. The HPA will update the IHP as required based on the assessment and IDT decisions.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 3rd, 2019
3. Lakeland Village Speech Pathologists have reviewed and updated the comprehensive Speech and Language assessment to include speech and language development, Comprehensive Communication Assessment to include what barriers are present, what services are available and what programs and services are recommended to assist meeting resident needs.
   Person Responsible: Beth Burke Speech Pathologist
   Completion date: September 26th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Disciplines responsible for assessing areas of the CFA will review their respective assessments against regulations to verify all required areas are being assessed. Upon completion of this review, all disciplines will collaboratively review all assessment areas of the CFA to verify all required areas identified in regulation are adequately assessed across disciplines to accurately identify each resident's individual needs.
   Person(s) Responsible: Lakeland Village IDT Members
   Completed by: October 15th, 2019
2. Speech Language Pathologists received training and guidance on the regulatory requirements around sensorimotor assessments.
   Person(s) Responsible: Westcare Management
   Completed by: October 15th, 2019
3. Speech Language Pathologists will review all current assessments to verify current assessments are comprehensive and meet regulatory required standards. Any identified deficit will be corrected and submitted to the resident's HPA.

This document was prepared by Residential Care Services for the Locator website.

Person(s) Responsible: Speech Language Pathologists
Completed by: November 22nd, 2019

4. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
5. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Quality Assurance Department will complete a 50% review of all full speech and language assessments completed in the next 6 months. Any identified deficits in assessing in regulatory required areas will be directly reported to the assigned discipline and their supervisor for correction. The Quality Assurance Department will work with Staff Development and other assigned disciplines in that area to develop focused training on reoccurring deficient areas. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD
Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W225

CFR and title

§483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The comprehensive functional assessment must include, as applicable, vocational skills.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Assigned disciplines were not fully aware of the regulatory requirements around their assessment area. Assessment templates were created using professional judgement, knowledge, and experience. This resulted in assessments that did not adequately assess required areas identified in regulations.

The plan correcting the specific deficiency.

1. Adult Programs will complete a Comprehensive Vocational Skills Assessment for Client #5.
   Person(s) Responsible: John Borneman, Adult Programs Supervisor
   Completed by: 10/11/2019
2. IDT will review Client #5's Comprehensive Vocational Skills Assessment and develop necessary supports and training programs to meet his needs. Client's IHP will be updated as indicated by IDT's discussion.
   Person(s) Responsible: Brittany Flores, HPA
   Completed by: October 25th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Disciplines responsible for assessing areas of the CFA will review their respective assessments against regulations to verify all required areas are being assessed. Upon completion of this review, all disciplines will collaboratively review all assessment areas of the CFA to verify all required areas identified in regulation are adequately assessed across disciplines to accurately identify each resident's individual needs.
   Person(s) Responsible: Lakeland Village IDT Members
   Completed by: October 15th, 2019
2. The Adult Programs Supervisor received training and guidance on the regulatory requirements around sensorimotor assessments.
   Person(s) Responsible: Westcare Management
   Completed by: October 15th, 2019
3. Adult Programs will review all current assessments to verify current assessments are comprehensive and meet regulatory required standards. Any identified deficit will be corrected and submitted to the resident's HPA.
   Person(s) Responsible: Adult Programs
   Completed by: November 22nd, 2019
4. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
5. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

This document was prepared by Residential Care Services for the Locator website.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Quality Assurance Department will complete a 50% review of all full vocational assessments completed in the next 6 months. Any identified deficits in assessing in regulatory required areas will be directly reported to the assigned discipline and their supervisor for correction. The Quality Assurance Department will work with Staff Development and other assigned disciplines in that area to develop focused training on reoccurring deficient areas. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W227

CFR and title

§483.440(c)(4) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

IDT members did not fully understand their regulatory obligation and how each member's contribution complimented other disciplines to create a comprehensive individual program plan that met the needs of the residents. This resulted in IDT members not fully participating in IDT meetings for residents, not understanding how the content of other discipline's assessments and recommendations could affect their own, and a lack of collaboration on program development for the individual. This resulted in needs being addressed in isolation of a collaborative IDT approach.

The plan correcting the specific deficiency.

Client 1

1. The IDT for Client #1 will meet to review Client #1's assessed needs. The IDT will review Client #1's Primary Need and make necessary revisions based on Client #1's assessed needs.
   Person(s) Responsible: Hillside IDT
   Complete by: 10/4/2019
2. The IDT for Client #1 will develop additional formal programs to increase his independence in activities of daily living.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/11/2019
3. Direct care staff who work with Client #1 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Jana McCluskey, HPA; Brian-Keith Jennings, ACM
   Completed by: October 18th, 2019
4. Current formal programs for Client #1 will be reviewed to verify special training considerations for moderate to severe hearing loss are included.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/1/2019

Client 3

5. Speech Pathologist will update Client #3's Comprehensive Communication Assessment to include, barriers to communication that are present, what services are available and what training/programs are needed to address his communication needs.
   Person Responsible: Beth Budke, Speech Pathologist
   Completion date: 10/4/2019
6. Client #3's Psychology Associate and SLP will conduct a collaborative evaluation to determine distinguishing characteristics of when Client #3 is grasping people's arm to gain their attention versus as a form of aggression. The IDT will develop necessary training programs and support to meet the identified need and function of both intended purposes of Client #3 grasping people's arm.

This document was prepared by Residential Care Services for the Locator website.

Person Responsible: Steve Allen, Psych Associate; Beth Budke, Speech Pathologist; Ben Johnson, HPA
Completion date: October 3rd, 2019

7. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to accurately reflect any necessary changes.
   Responsible person: Ben Johnson, HPA
   Completed by: 10/4/2019

Client 5

8. Client #5's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs.
   Person(s) Responsible: Bigfoot IDT
   Completed by: 10/4/2019
9. Direct Care staff who work with Client #5 will be trained on the new formal programs and programs will be implemented.
   Person(s) Responsible: Brittany Flores, HPA; Angela Fabrizio, ACM
   Completed by: October 18th, 2019
10. Client #5's HPA will facilitate a follow up observation of Client #5's day to verify formal programming is meeting his assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Brittany Flores, HPA
    Completed by: 10/31/2019

Client 6

11. Client #6's IDT will meet to review his assessments and develop additional formal programs to meet his assessed needs to decrease his dependence on cues, increase independence during meals, and increase intentional communication skills.
    Person(s) Responsible: Apple IDT
    Completed by: 10/4/2019
12. Direct Care staff who work with Client #6 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Julie Driscoll, HPA; Patty Thomas, ACM
    Completed by: October 18th, 2019
13. Client #6's HPA will facilitate a follow up observation of Client #6's day to verify formal programming is meeting his assessed need as well as verify the training is continuous and aggressive. The IDT will develop additional formal programming as required based on this observation.
    Person(s) Responsible: Julie Driscoll, HPA
    Completed by: 10/31/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will receive additional training on including the identified needs of the CFA in the resident's IHP. This training will include prioritization of needs as well as verifying the supports identified in the IHP are sufficient in meeting the identified needs in the CFA.
   Person(s) Responsible: Westcare Management and Staff Development
   Completed by: December 5th, 2019
2. IDT members responsible for completing resident assessments will review current assessments to verify they accurately identify the residents' needs and meet regulatory requirements of the CFA.
   Person(s) Responsible: IDT Members
   Completed by: November 4th, 2019

This document was prepared by Residential Care Services for the Locator website.

3. All members of the ICF Core team have received training on the regulatory requirements of the IDT. This training included how the IDT functions together, how assessments work together to create the Comprehensive Functional Assessment for the resident, and how the HPA facilitates IDT collaboration in the development of the residents IHP.
   Person(s) Responsible: Westcare Management
   Completed by: October 9th, 2019
4. Staff Development is creating additional IDT training for ICF Core Team members to promote further regulatory understanding of each member's role in supporting the development of the residents IHP and meeting the residents identified needs.
   Person(s) Responsible: Staff Development
   Completed by: December 31st, 2019
5. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
6. Westcare consultants will sit in on the IDT meetings scheduled to between November 4th thru the 22nd. Consultants will help facilitate where needed as well as provide ongoing coaching, training, and mentoring of HPAs directly after the meetings to help verify the resident needs identified are accurately captured and addressed.
   Person(s) Responsible: Westcare Management
   Completed by: Initiated on November 4th, 2019 and ongoing through December of 2019
7. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify resident needs are met. HPAs will provide direct any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director
Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

This document was prepared by Residential Care Services for the Locator website.

Tag number

W230

CFR and title

§483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The objectives of the individual program plan must be assigned projected completion dates.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current Program Description Form did not clearly identify the assigned projected completion date of the objectives of the individual program plan. The Program Description Form is compressed which results in difficulty in identifying required information of the objective.

The plan correcting the specific deficiency.

1. Client #4's formal programs will be updated to set projected completion dates based on her rate of learning.
   Person(s) Responsible: Nora McKinney, HPA
   Completed By: October 18th, 2019
2. Client #6's formal programs will be updated to set projected completion dates based on his rate of learning.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 18th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will review each resident's formal programs and verify projected completion dates and success criteria are based on each resident's rate of learning.
   Person(s) Responsible: Facility HPAs
   Completed by: 11/30/2019
2. Lakeland Village has modified its Program Description Form (the template used to document instructions of formal programs) to be more intuitive, promote regulatory compliance, and promote consistency of implementation.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019
3. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
4. HPAs will receive additional training on writing objectives and formal programs.
   Person(s) Responsible: Westcare Management
   Completed by: December 4th, 2019.
5. HPAs will facilitate collaborative development of formal programs (utilizing Program Teaching Instructions Template) based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

This document was prepared by Residential Care Services for the Locator website.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete monthly analysis of formal program data. During this review, HPAs will review formal programs to verify the assigned projected completion date is present and still accurate based on current resident progress. HPAs will facilitate any necessary program revisions and documentation based on their review.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W234

CFR and title

§483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current Program Description Form did not clearly identify the assigned projected completion date of the objectives of the individual program plan. The Program Description Form is compressed which results in difficulty in identifying required information of the objective. This also resulted in written training programs not clearly specifying the methods to be used.

The plan correcting the specific deficiency.

1. The identified formal programs for Client #6 will be revised to provide clear detailed instructions to staff who implement the programs.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 18th, 2019
2. HPA will complete follow up observations on the revised programs being implemented to verify the program revisions provide clear detailed instructions and staff are able to accurately follow the teaching instructions.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: 10/31/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will review all current formal programs to verify that the teaching strategies provide clear detailed instructions to all staff. Any identified deficit or concern will be addressed by the resident's IDT.
   Person(s) Responsible: Facility HPAs
   Completed by: November 27th, 2019
2. Lakeland Village has modified its Program Description Form (the template used to document instructions of formal programs) to be more intuitive, promote regulatory compliance, and promote consistency of implementation.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019
3. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
4. HPAs will receive additional training on writing objectives and formal programs.
   Person(s) Responsible: Westcare Management
   Completed by: December 4th, 2019.
5. HPAs will facilitate collaborative development of formal programs (utilizing Program Teaching Instructions Template) based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

This document was prepared by Residential Care Services for the Locator website.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Renee Schuiteman, DDA
Lorraine McConahy, DDA

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W236

CFR and title

§483.440(c)(5)(iii) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

Each written training program designed to implement the objectives in the individual program plan must specify the person responsible for the program.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current Program Description Form did not clearly identify the assigned projected completion date of the objectives of the individual program plan. The Program Description Form is compressed which results in difficulty in identifying required information of the objective.

The plan correcting the specific deficiency.

1. HPAs for the identified residents will review and analyze all program data collected. HPAs will report any concerns to the resident's IDT for collaboration and revisions to verify accurate data is being taken as well as analyzed.
   Person(s) Responsible: Facility HPAs
   Completed by: October 15th, 2019
2. HPAs have been directed to conduct direct analysis of formal program data. This includes a direct analysis of the program data collection sheet to identify potential trends, areas of concerns, or potential early advancement of the program based on the review and IDT decision.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: 9/25/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Lakeland Village has modified its Program Description Form (the template used to document instructions of formal programs) to be more intuitive, promote regulatory compliance, and promote consistency of implementation.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019
2. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
3. HPAs will receive additional training on writing objectives and formal programs.
   Person(s) Responsible: Westcare Management
   Completed by: December 4th, 2019.
4. HPAs will facilitate collaborative development of formal programs (utilizing Program Teaching Instructions Template) based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

This document was prepared by Residential Care Services for the Locator website.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete monthly analysis of formal program data. During this review, HPAs will review formal programs to verify the person responsible is present and still accurate based on current resident progress. HPAs will facilitate any necessary program revisions and documentation based on their review.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Renee Schuiteman, DDA
Lorraine McConahy, DDA

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

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This document was prepared by Residential Care Services for the Locator website.

Tag number

W242

CFR and title

§483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

IDT members did not fully understand their regulatory obligation and how each member's contribution complimented other disciplines to create a comprehensive individual program plan that met the needs of the residents. This resulted in IDT members not fully participating in IDT meetings for residents, not understanding how the content of other discipline's assessments and recommendations could affect their own, and a lack of collaboration on program development for the individual. This resulted in needs being addressed in isolation of a collaborative IDT approach.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents.

HPAs do not submit completed IHPs to a supervisor or a peer for review prior to implementation. This has resulted in a lack of oversight for regulatory required information and programing being present in an IHP.

The plan correcting the specific deficiency.

1. The IDT for Client #1 will meet to review Client #1's assessed needs. The IDT will review Client #1's Primary Need and make necessary revisions based on Client #1's assessed needs.
   Person(s) Responsible: Hillside IDT
   Complete by: 10/4/2019
2. The IDT for Client #1 will develop additional formal programs to increase his independence in activities of daily living.
   Person(s) Responsible: Jana McCluskey, HPA
   Completed by: 10/11/2019
3. Direct care staff who work with Client #1 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Jana McCluskey, HPA; Brian-Keith Jennings, ACM
   Completed by: October 18th, 2019
4. IDT will meet to review Client #2's assessments and develop formal programs to meet his assessed needs.
   Person(s) Responsible: 86/87 Cascade IDT
   Completed by: 10/4/2019

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5. IDT for Client #2 will develop additional formal programming based on assessment review to support improving mental stability and increase independence in activities of daily living.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 10/11/2019
6. Direct care staff who work with Client #2 will be trained on the new formal programs, and programs will be implemented.
   Person(s) Responsible: Nora McKinney, HPA; Angela Moseanko, ACM
   Completed by: October 18th, 2019
7. Speech Pathologist will update Client #3's Comprehensive Communication Assessment to include, barriers to communication that are present, what services are available and what training/programs are needed to address his communication needs.
   Person Responsible: Beth Budke, Speech Pathologist
   Completion date: 10/4/2019
8. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to include a formal communication program and to accurately reflect any necessary changes.
   Responsible person: Ben Johnson, HPA
   Completed by: 10/4/2019
9. Direct care staff who work with Client #3 will receive training on any new or updated programs as well as any IHP revisions.
   Person(s) Responsible: Ben Johnson HPA
   Completed by: 10/11/2019
10. Client #4's IDT will meet to review her assessments and develop additional formal programs to meet her assessed needs.
    Person(s) Responsible: Evergreen IDT
    Completed by: 10/4/2019
11. Direct Care staff who work with Client #4 will be trained on the new formal programs and programs will be implemented.
    Person(s) Responsible: Nora McKinney, HPA; Raleigh Stowe, ACM
    Completed by: October 18th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will receive additional training on including the identified needs of the CFA in the resident's IHP. This training will include prioritization of needs as well as verifying the supports identified in the IHP are sufficient in meeting the identified needs in the CFA.
   Person(s) Responsible: Westcare Management and Staff Development
   Completed by: December 5th, 2019
2. IDT members responsible for completing resident assessments will review current assessments to verify they accurately identify the residents' needs and meet regulatory requirements of the CFA.
   Person(s) Responsible: IDT Members
   Completed by: November 4th, 2019
3. All members of the ICF Core team have received training on the regulatory requirements of the IDT. This training included how the IDT functions together, how assessments work together to create the Comprehensive Functional Assessment for the resident, and how the HPA facilitates IDT collaboration in the development of the residents IHP.
   Person(s) Responsible: Westcare Management

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Completed by: October 9th, 2019

4. Staff Development is creating additional IDT training for ICF Core Team members to promote further regulatory understanding of each member's role in supporting the development of the residents IHP and meeting the residents identified needs.
   Person(s) Responsible: Staff Development
   Completed by: December 31st, 2019
5. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
6. Westcare consultants will sit in on the IDT meetings scheduled to between November 4th thru the 22nd. Consultants will help facilitate where needed as well as provide ongoing coaching, training, and mentoring of HPAs directly after the meetings to help verify the resident needs identified are accurately captured and addressed.
   Person(s) Responsible: Westcare Management
   Completed by: Initiated on November 4th, 2019 and ongoing through December of 2019
7. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD
Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W247

CFR and title

§483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN

Specific language from CFR

The individual program plan must include opportunities for client choice and self-management.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

All ICF employees did not have a thorough understanding of how the regulations work together to require a comprehensive system of supports and service to meet the resident needs. This resulted in individuals understanding singular and sometimes clusters of regulations in isolation of the overall intent of all the regulations together. This has resulted in IDT members not having a clear understanding of the overall intent of meeting residents identified needs, while incorporating and promoting resident choice and self-management, in hopes of moving to a less restrictive environment.

The plan correcting the specific deficiency.

1. Direct care staff who support Client #1 will receive training on providing him the necessary support and time to make his own choices throughout the day.
   Person Responsible: Jana McCluskey, HPA
   Completed by: October 15th, 2019
2. Direct care staff who support Client #3 will receive training on providing him the necessary support and time to make his own choices throughout the day.
   Person Responsible: Ben Johnson, HPA
   Completed by: October 15th, 2019
3. Direct care staff who support Client #9 will receive training on providing her the necessary support and time to make her own choices throughout the day.
   Person Responsible: Jana McCluskey, HPA
   Completed by: October 15th, 2019
4. Direct care staff who support Client #9 will receive training on supports versus restrictions and resident rights.
   Person(s) Responsible: Staff Development Department
   Completed by: October 25th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

13. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need, promote continuous and aggressive active treatment, and incorporate and promote resident choice and self-management.
    Person(s) Responsible: Facility HPAs
    Completed by: November 22nd, 2019
14. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
    Person(s) Responsible: Facility HPAs
    Completed by: December 31st, 2019

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15. All ICF employees will receive additional training on the regulatory requirements of active treatment. Including how resident choice and self-management are essential components of active treatment.
    Person(s) Responsible: Westcare Management, LV Staff Development
    Completed by: January 31st, 2020

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The Quality Assurance Department will conduct routine Active Treatment Observations to verify training needs are met, active treatment is continuous and aggressive, program implementation is occurring as expected, and resident choice and self-management is promoted. The Quality Assurance Department will provide direct feedback to staff they observed. Any identified deficit will be reported to the HPA and the area supervisor for resolution.

The title of the person or persons responsible for implementing the acceptable plan of correction

Renee Schuiteman, DDA
Lorraine McConahy, DDA

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

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This document was prepared by Residential Care Services for the Locator website.

Tag number

W251

CFR and title

§483.440(d)(3) PROGRAM IMPLEMENTATION

Specific language from CFR

Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

All ICF employees did not have a thorough understanding of how the regulations work together to require a comprehensive system of supports and service to meet the resident needs. This resulted in individuals understanding singular and sometimes clusters of regulations in isolation of the overall intent of all the regulations together. This has resulted in IDT members not having a clear understanding of the overall intent of meeting residents identified needs in hopes of moving to a less restrictive environment.

The plan correcting the specific deficiency.

1. The identified staff will receive additional training on how to implement Client #3's formal program K.08.
   Person(s) Responsible: Erica Horton, RN3
   Completed by: 10/4/2019
2. The identified staff will receive additional training on how to implement Client #6's formal program.
   Person(s) Responsible: Mike Ellis
   Completed by: 9/19/2019
3. The identified formal programs for Client #6 will be revised to provide clear detailed instructions to staff who implement the programs.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 18th, 2019
4. HPA will complete follow up observations on the revised programs being implemented to verify the program revisions provide clear detailed instructions and staff are able to accurately follow the teaching instructions.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: 10/31/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will review all current formal programs to verify that the teaching strategies provide clear detailed instructions to all staff. Any identified deficit or concern will be addressed by the resident's IDT.
   Person(s) Responsible: Facility HPAs
   Completed by: November 27th, 2019
2. Lakeland Village has modified its Program Description Form (the template used to document instructions of formal programs) to be more intuitive, promote regulatory compliance, and promote consistency of implementation.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019

This document was prepared by Residential Care Services for the Locator website.

3. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
4. HPAs will receive additional training on writing objectives and formal programs.
   Person(s) Responsible: Westcare Management
   Completed by: December 4th, 2019.
5. HPAs will facilitate collaborative development of formal programs (utilizing Program Teaching Instructions Template) based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019
6. Lakeland Village has changed its graduated guidance model (the hierarchy of supports implemented to assist a resident to learn a new skill) to be more intuitive and align with nationally accepted and used standards.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: October, 15th, 2019
7. All Lakeland Village ICF employees will be trained in the new graduated guidance model.
   Person(s) Responsible: Staff Development
   Completed by: December 31st 2019
8. Lakeland Village has modified the current Active Treatment Schedule (ATS) to more clearly identify the formal training programs, informal objectives, and the skills to be maintained for each resident. This schedule also more clearly identifies when each of these training opportunities is likely to occur for the residents.
   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: November 20th, 2019
9. All resident ATS will be updated to the new format and include any new training programs, informal objective or skills to be maintained identified from the updated IHP meetings.
   Person(s) Responsible: ACMs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

This document was prepared by Residential Care Services for the Locator website.

The Quality Assurance Department will conduct routine Active Treatment Observations to verify training needs are met, active treatment is continuous and aggressive, program implementation is occurring as expected, and resident choice and self-management is promoted. The Quality Assurance Department will provide direct feedback to staff they observed. Any identified deficit will be reported to the HPA and the area supervisor for resolution.

Lakeland Village will develop an ICF Quality Assurance and Process Improvement Committee. This committee will consist of membership for staff representation from each department or service area in the ICF. This committee reviews current systems at Lakeland Village, identify areas for improvement, as well as identifying best practice. Quarterly reports will be provided to the Lakeland Village executive leadership team for review and determination of additional support needed.

The title of the person or persons responsible for implementing the acceptable plan of correction

Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W318

CFR and title

§483.460 HEALTH CARE SERVICES

Specific language from CFR

The facility must ensure that specific health care services requirements are met.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The caseload distribution for the medical providers for the ICF was disproportionate. This resulted in a lack in efficiency and hindered the provider response. Lakeland Village's current procedure for a resident's change in condition did not clearly identify the provider's responsibility for response. This resulted in an inefficient and inconsistent practice to how medical providers responded to medical changes of condition.

Lakeland Village has not had a medical director overseeing health care services for the ICF. This has resulted in different departments working at times in isolation of one another to meet the resident need.

The plan correcting the specific deficiency.

1. The IDT for Client #2 developed and implemented a comprehensive plan of care.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 8/24/2019
2. LV Procedure 8.6 "Medical Appointments" has been updated to include a process for medical appointments and consultant's recommendation. This process includes:
   a. IDT process for scheduling a medical appointment
   b. Development of any necessary pre-appointment care plans;
   c. Facilitation of IDT discussion on the results of the appointment, including the IDT's decision with regards to the consultant's recommendation and the IDTs plan to meet the resident's identified need; and
   d. Development and implementation of all necessary post appointment care plans, revisions or updates to the resident's IHP.

   Person(s) Responsible: Brendan Arkoosh QAD
   Completed by: August 28th, 2019
3. LV Form 30-101A "IDT Appointment Follow-up" has been implemented to document the outcome of a resident's appointment and the IDT's plan.
   Person Responsible: Brendan Arkoosh
   Completed by: August 28th, 2019
4. Client #6 was seen by the gastroenterologist on 9/18/2019. A colonoscopy and an upper endoscopy was completed during this appointment. Reports of this evaluation noted no concerns and for Client #6 to have a repeat colonoscopy in four (4) years.
   Person(s) Responsible: Mike Ellis, Team Lead RN
   Completed by:9/18/2019
5. Client #6's IDT has reviewed the gastroenterologist's recommendation and developed a comprehensive medical care plan to meet the identified needs.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: 9/25/19

This document was prepared by Residential Care Services for the Locator website.

6. Client #6's medical provider changed the order for Linzess 290micrograms to be administered prior to breakfast.
   Person(s) Responsible: Maureen Elston, ARNP
   Completed by: 9/19/2019
7. The facility is actively pursuing a contract with a licensed dentist for 24/7 guidance and provision of emergency services for clients.
   Person(s) Responsible: Sharlene Gentry, Assistant Superintendent
   Completed by: 12/31/2019
8. The facility's licensed dentist is currently available after hours for guidance and provisions of emergency services for clients.
   Person(s) Responsible: Ann-Marie Monson, DDS
9. The identified licensed nurse will be retrained on the medication administration process.
   Person(s) Responsible: Nathan Cates, RN3 Nurse Educator
   Completed by: October 8th, 2019
10. The identified licensed nurses competency was verified through a medication pass observation.
    Person(s) Responsible: Nathan Cates, RN3 Nurse Educator
    Completed by: October 15th, 2019
11. All licensed nursing staff will be retrained on Nursing Procedure "General Principles of Medication Administration."
    Person(s) Responsible: Nathan Cates, RN3 Nurse Educator
    Completed by: November 27th, 2019
12. A currently employed Lakeland Village medical provider, an Advanced Registered Nurse Practitioner, has expanded their caseload on the ICF to establish more effectively managed caseloads for the medical providers.
    Person(s) Responsible: Connie Lambert-Eckel, Superintendent
    Completed by: November 4th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. A Position Description Form (PDF) has been developed for a Physician to be the Medical Director for Lakeland Village ICF. This PDF has been submitted to Class and Compensation. This position will supervise medical providers on the ICF as well as be responsible for a caseload of residents.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 6th, 2019
2. The Superintendent will work with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 13th, 2019
3. Interviews will be conducted with qualified candidates.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 6th, 2019
4. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Superintendent will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 13th, 2019

This document was prepared by Residential Care Services for the Locator website.

5. Lakeland Village Procedure 8.9 "Resident Change in Condition" will be updated to include provider expectations, including assessment and documentation, when they have been notified of a resident change in condition.
   Person(s) Responsible: Rebecca Campbell, RN 4
   Completed by: 11/27/19
6. Medical Providers will be trained on the updated LV Procedure 8.9 "Resident Change in Condition."
   Person(s) Responsible: Brendan Arkoosh, QAD; Rebecca Campbell, RN4
   Completed by: December 3rd, 2019
7. Medical providers on the ICF will receive direction on routine observation or "rounding" of residents on their assigned caseload. These observations will be to evaluate current course of treatment on acute issues, complete necessary assessments, and follow up with IDT members about any concerns they may have about a particular resident.
   Person(s) Responsible: Teri Gilden, ICF Program Area Team (PAT) Director
   Completed by: November 13th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The ICF Medical Director, once hired, will monitor medical providers' assessments and adherence to Lakeland Village procedure as well as standards of practice for medical providers. Any identified performance deficits identified will be addressed.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director
Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W320

CFR and title

§483.450(a)(2) PHYSICIAN SERVICES

Specific language from CFR

The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements. Review of relevant internal procedures revealed inconsistent and conflicting information.

The caseload distribution for the medical providers for the ICF was disproportionate. This resulted in a lack in efficiency and hindered the provider response. Lakeland Village's current procedure for a resident's change in condition did not clearly identify the provider's responsibility for response. This resulted in an inefficient and inconsistent practice to how medical providers responded to medical changes of condition.

Lakeland Village has not had a medical director overseeing health care services for the ICF. This has resulted in different departments working at times in isolation of one another to meet the resident need.

The plan correcting the specific deficiency.

1. The IDT for Client #2 developed and implemented a comprehensive plan of care.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 8/24/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. LV Procedure 8.6 "Medical Appointments" has been updated to include a process for medical appointments and consultant's recommendation. This process includes:
   a. IDT process for scheduling a medical appointment
   b. Development of any necessary pre-appointment care plans;
   c. Facilitation of IDT discussion on the results of the appointment, including the IDT's decision with regards to the consultant's recommendation and the IDTs plan to meet the resident's identified need; and
   d. Development and implementation of all necessary post appointment care plans, revisions or updates to the resident's IHP.

   Person(s) Responsible: Brendan Arkoosh QAD
   Completed by: August 28th, 2019
2. LV Form 30-101A "IDT Appointment Follow-up" has been implemented to document the outcome of a resident's appointment and the IDT's plan.
   Person Responsible: Brendan Arkoosh
   Completed by: August 28th, 2019
3. A Position Description Form (PDF) has been developed for a Physician to be the Medical Director for Lakeland Village ICF. This PDF has been submitted to Class and Compensation. This position will supervise medical providers on the ICF as well as be responsible for a caseload of residents.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 6th, 2019
4. The Superintendent will work with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.

This document was prepared by Residential Care Services for the Locator website.

Person(s) Responsible: Connie Lambert-Eckel, Superintendent
Completed by: November 13th, 2019

5. Interviews will be conducted with qualified candidates.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 6th, 2019
6. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Superintendent will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 13th, 2019
7. Lakeland Village Procedure 8.9 "Resident Change in Condition" will be updated to include provider expectations, including assessment and documentation, when they have been notified of a resident change in condition.
   Person(s) Responsible: Rebecca Campbell, RN 4
   Completed by: 11/27/19
8. Medical Providers will be trained on the updated LV Procedure 8.9 "Resident Change in Condition."
   Person(s) Responsible: Brendan Arkoosh, QAD; Rebecca Campbell, RN4
   Completed by: December 3rd, 2019
9. Medical providers on the ICF will receive direction on routine observation or "rounding" of residents on their assigned caseload. These observations will be to evaluate current course of treatment on acute issues, complete necessary assessments, and follow up with IDT members about any concerns they may have about a particular resident.
   Person(s) Responsible: Teri Gilden, ICF Program Area Team (PAT) Director
   Completed by: November 13th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs and Team Lead RNs will complete a review of 50% review of all off campus appointments for the next month to verify LV Procedure 8.6A was followed. This review will include verifying all associated care plans are in place as indicated on LV 30-101A IDT Appointment Follow-up. The frequency of this review will decrease, as sustainable compliance is evident. Any identified deficiency will be corrected.

The DDAs and the RN4 will complete regular reviews of resident appointments to verify all LV 8.6 was followed. This review will include verifying all associated care plans area in place as indicated on LV 30-101A. Any identified deficit will be reported to the identified HPA, Team Lead RN, and their supervisor for resolution.

The Hospital Review Committee will verify that this process is followed for all hospitalizations they review. Any identified deficit will be immediately reported to the HPA, Team Lead RN, and supervisor for resolution.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director
Rebecca Campbell, RN4

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

This document was prepared by Residential Care Services for the Locator website.

Tag number

W322

CFR and title

§483.460(a)(3) PHYSICIAN SERVICES

Specific language from CFR

The facility must provide or obtain preventive and general medical care.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Lakeland Village has not had a medical director overseeing health care services for the ICF. This has resulted in different departments working at times in isolation of one another to meet the resident need.

The plan correcting the specific deficiency.

1. The IDT for Client #2 has developed and implemented a comprehensive plan of care.
   Person(s) Responsible: Nora McKinney, HPA
   Completed by: 8/24/2019
2. LV Procedure 8.6 "Medical Appointments" has been updated to include a process for medical appointments and consultant's recommendation. This process includes:
   a. IDT process for scheduling a medical appointment
   b. Development of any necessary pre-appointment care plans;
   c. Facilitation of IDT discussion on the results of the appointment, including the IDT's decision with regards to the consultant's recommendation and the IDTs plan to meet the resident's identified need; and
   d. Development and implementation of all necessary post appointment care plans, revisions or updates to the resident's IHP.

   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: August 28th, 2019
3. LV Form 30-101A "IDT Appointment Follow-up" has been implemented to document the outcome of a resident's appointment and the IDT's plan.
   Person Responsible: Brendan Arkoosh
   Completed by: August 28th, 2019
4. Staff who support Client's #2 and Client #8 received training on "Handwashing and Sanitation of surfaces and equipment to prevent the spread of infection." Upon identifying on 8/2/2019, the source of the infection as a transmission of an organism from one client to another this training was initiated.
   Person(s) Responsible: Karen Maher, RN 3 IP, Kate Olson, Pharmacist, Kathy Evenson TLRN
   Completed: 9/10/2019
5. Client #6 was seen by a cardiologist on 4/8/2019. The cardiologist reviewed the previous year's echocardiogram and assessed Client #6's cardiac health and indicated the "cardiac examination is normal." The cardiologist recommended a repeat echocardiogram in one (1) year.
   Person(s) Responsible: Mike Ellis, Team Lead RN
   Completed by: 9/20/2019

This document was prepared by Residential Care Services for the Locator website.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. A Position Description Form (PDF) has been developed for a Physician to be the Medical Director for Lakeland Village ICF. This PDF has been submitted to Class and Compensation. This position will supervise medical providers on the ICF as well as be responsible for a caseload of residents.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 6th, 2019
2. The Superintendent will work with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 13th, 2019
3. Interviews will be conducted with qualified candidates.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 6th, 2019
4. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Superintendent will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 13th, 2019
5. LV Procedure 8.6 "Medical Appointments" will be updated to include processes to track when clients have required follow up appointments for specialized medical services. This process includes notification of the IDT members, as well as utilizing automated reminders for IDT members to verify follow up appointments are scheduled.
   Person(s) Responsible: Becky Campbell, RN4
   Completed by: 10/4/2019
6. Lakeland Village's Antibiotic Stewardship committee has implemented a new antibiotic tracking system. This system tracks and reports on:
   - When residents has been prescribed antibiotics,
   - What antibiotic the resident was prescribed and justification,
   - The original length of time of the order as well as any deviation,
   - What tests were utilized prior to antibiotics being prescribed,
   - Aggregated information on frequency of antibiotic use by resident, by antibiotic, and justification.

   Person(s) Responsible: Karen Maher, Infection Preventionist
   Completed by: September 26th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The Antibiotic Stewardship Committee meets at least monthly to review antibiotic use and systems in place to prevent the need for antibiotic use. Lakeland Village has partnered with John Hopkins to provide continued guidance about antibiotic stewardship.

The title of the person or persons responsible for implementing the acceptable plan of correction

Rebecca Campbell, RN4
Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

This document was prepared by Residential Care Services for the Locator website.

Tag number

W338

CFR and title

§483.460(c)(3)(v) NURSING SERVICES

Specific language from CFR

Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems).

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Lakeland Village has not had a medical director overseeing health care services for the ICF. This has resulted in different departments working at times in isolation of one another to meet the resident need.

The plan correcting the specific deficiency.

1. Client #6 was seen by the gastroenterologist on 9/18/2019. A colonoscopy and an upper endoscopy was completed during this appointment. Reports of this evaluation noted no concerns and for Client #6 to have a repeat colonoscopy in four (4) years.
   Person(s) Responsible: Mike Ellis, Team Lead RN
   Completed by: 9/18/2019
2. Client #6's IDT has reviewed the gastroenterologist's recommendation and developed a comprehensive medical care plan to meet the identified needs.
   Person(s) Responsible: Julie Driscoll
   Completed by: 9/25/2019
3. Client #6's medical provider changed the order for Linzess 290micrograms to be administered prior to breakfast.
   Person(s) Responsible: Maureen Elston, ARNP
   Completed by: 9/19/2019
4. Client #6 had a CT Colonography as recommended by the gastroenterologist on 9/18/19.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: November 6th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. LV Procedure 8.6 "Medical Appointments" has been updated to include a process for medical appointments and consultant's recommendation. This process includes:
   a. IDT process for scheduling a medical appointment
   b. Development of any necessary pre-appointment care plans;
   c. Facilitation of IDT discussion on the results of the appointment, including the IDT's decision with regards to the consultant's recommendation and the IDTs plan to meet the resident's identified need; and
   d. Development and implementation of all necessary post appointment care plans, revisions or updates to the resident's IHP.

   Person(s) Responsible: Brendan Arkoosh, QAD
   Completed by: August 28th, 2019

This document was prepared by Residential Care Services for the Locator website.

2. LV Form 30-101A "IDT Appointment Follow-up" has been implemented to document the outcome of a resident's appointment and the IDT's plan.
   Person Responsible: Brendan Arkoosh
   Completed by: August 28th, 2019
3. LV Procedure 8.6 "Medical Appointments" will be updated to include processes to track when clients have required follow up appointments for specialized medical services. This process includes notification of the IDT members, as well as utilizing automated reminders for IDT members to verify follow up appointments are scheduled.
   Person(s) Responsible: Becky Campbell, RN4
   Completed by: 10/4/2019
4. A Position Description Form (PDF) has been developed for a Physician to be the Medical Director for Lakeland Village ICF. This PDF has been submitted to Class and Compensation. This position will supervise medical providers on the ICF as well as be responsible for a caseload of residents.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 6th, 2019
5. The Superintendent will work with the Department of Social and Health Services to create a recruitment notice to attract qualified candidates for the position.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: November 13th, 2019
6. Interviews will be conducted with qualified candidates.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 6th, 2019
7. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the Superintendent will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Connie Lambert-Eckel, Superintendent
   Completed by: December 13th, 2019
8. Medical providers on the ICF will receive direction on routine observation or "rounding" of residents on their assigned caseload. These observations will be to evaluate current course of treatment on acute issues, complete necessary assessments, and follow up with IDT members about any concerns they may have about a particular resident.
   Person(s) Responsible: Teri Gilden, ICF Program Area Team (PAT) Director
   Completed by: November 13th, 2019
9. See Plan of Correction for W339 for additional details concerning nursing.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs and Team Lead RNs will complete a review of 50% review of all off campus appointments for the next month to verify LV Procedure 8.6A was followed. This review will include verifying all associated care plans are in place as indicated on LV 30-101A IDT Appointment Follow-up. The frequency of this review will decrease, as sustainable compliance is evident. Any identified deficiency will be corrected.

The DDAs and the RN4 will complete regular reviews of resident appointments to verify all LV 8.6 was followed. This review will include verifying all associated care plans area in place as indicated on LV 30-101A. Any identified deficit will be reported to the identified HPA, Team Lead RN, and their supervisor for resolution.

This document was prepared by Residential Care Services for the Locator website.

The Hospital Review Committee will verify that this process is followed for all hospitalizations they review. Any identified deficit will be immediately reported to the HPA, Team Lead RN, and supervisor for resolution.

The title of the person or persons responsible for implementing the acceptable plan of correction

Rebecca Campbell, RN4
Brendan Arkoosh, QAD

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W339

CFR and title

§483.460(c)(4) NURSING SERVICES

Specific language from CFR

Nursing services must include other nursing care as prescribed by the physician or as identified by client needs.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The facility has not had a nurse educator dedicated to training and nursing skill competency evaluations of licensed nurses. This has resulted in lack of consistent nursing skill training as well as consistent competency evaluations.

The plan correcting the specific deficiency.

1. The nurse educator will provide additional training to licensed nursing staff with regards to the INTERACT process, which includes guidance and structure for acute assessments, interventions, and when to notify the client's provider based on an assessed acute or chronic issue.
   Person(s) Responsible: Nathan Cates, RN Nurse Educator
   Completed by: November 27th, 2019
2. The RN4 will develop a structured nursing shift exchange process that will promote a thorough report between nurses on each shift. The structured nursing shift exchange will also indicate new acute medical issues any client may be experiencing, critical documentation that should be reviewed, as well as any significant events that may have occurred on the previous shift.
   Person(s) Responsible: Becky Campbell, RN4
   Completed by: November 22nd, 2019
3. Client #6's IDT in coordination with the provider have assessed his current medication regimen and modified existing orders to provide additional clarity and direction to nursing staff.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 18th, 2019
4. A Chronic Care Plan concerning pain will be developed to delineate hierarchical assessment criteria for nursing staff to follow in order to determine appropriate interventions.
   Person(s) Responsible: Rebecca Campbell, RN4
   Completed by: October 2nd, 2019
5. The Psychology Associate in coordination with medical staff will conduct an assessment to determine the function of Client #6's reported self-injurious behavior.
   Person(s) Responsible: Rikki Miller, Psychology Associate, Mike Ellis, Team Lead RN
   Completed by: October 18th, 2019
6. The IDT will review the Psychology Associate's assessment and recommendation and make any necessary revisions to Client #6's IPP.
   Person(s) Responsible: Julie Driscoll, HPA
   Completed by: October 25th, 2019
7. Client #6 was evaluated by medical staff and had a CT scan that indicated [redacted] A follow up bladder scan was conducted and indicated that Client #6 was experiencing urinary retention of approximately 300 to 800 cc of fluid after he voids. An Acute Nursing Care Plan was developed and implemented to provide preventative measures as well as routine diagnostic testing.

This document was prepared by Residential Care Services for the Locator website.

Person(s) Responsible: Mike Ellis, Team Lead RN
Completed by: September 6th, 2019

8. Direct care and nursing staff have received training on the expectations and how to implement the Acute Nursing Care Plan identified in five above.
   Person(s) Responsible: Mike Ellis, Team Lead RN
   Completed by: October 18th, 2019
9. The nurse educator will train licensed nurses on urinary catheterization to include what to do if retention is noted. Practical skill observation to verify competency in these techniques will also occur with each licensed nurse.
   Person(s) Responsible: Nathan Cates, Nurse Educator
   Completed by: November 27th, 2019.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. The facility has hired a nurse educator to provide clinical and practical training and education to licensed nursing staff. This includes preceptorship for new nurses, verifying nursing competency on core tasks as well as ongoing education and monitoring procedures, documentation requirements and data monitoring.
   Person(s) Responsible: Kortne Reed, Clinical Nurse Specialist
   Completed by: September 16th, 2019
2. The nurse educator initiates regular training with licensed nurses. Training includes knowledge acquisition testing prior to the engagement of skill observation to verify competency.
   Person(s) Responsible: Nathan Cates, Nurse Educator
   Completed by: Initiated October 2019 and is ongoing.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

The nurse educator will facilitate ongoing nursing competency evaluations with licensed nurses. These evaluations occur at least twice a quarter and cover an array of required nursing competencies. Competencies chosen to evaluate are determined based on current facility compliance and identified deficits. Any identified deficits with a nurse during a competency evaluation will be reported to the supervisor and additional training will occur to verify competency is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Rebecca Campbell, RN4

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W355

CFR and title

§483.460(g)(1) COMPREHENSIVE DENTAL TREATMENT

Specific language from CFR

The facility must ensure comprehensive dental treatment services that include the availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

Explain the process that lead to this deficiency.

The facility has not had a contracted licensed dentist to provide guidance and provisions for emergency services when the facility's licensed dentist is not available.

The plan correcting the specific deficiency.

1. The facility is actively pursuing an agreement with a licensed dentist for 24/7 guidance and provision of emergency services for clients.
   Person(s) Responsible: Sharlene Gentry, Assistant Superintendent
   Completed by: December 31st, 2019
2. The facility's licensed dentist is currently available after hours for guidance and provisions of emergency services for clients.
   Person(s) Responsible: Ann-Marie Monson, DDS

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. All contracts are reviewed on a regular basis to verify the services identified in the contract are provided. Contract renewal is initiated in sufficient time to verify contracts do not expire.
   Person(s) Responsible: Lari Ash, AA3
   Completed by: Ongoing

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. All contracts are reviewed on a regular basis to verify the services identified in the contract are provided. Contract renewal is initiated in sufficient time to verify contracts do not expire.
   Person(s) Responsible: Lari Ash, AA3
   Completed by: Ongoing

The title of the person or persons responsible for implementing the acceptable plan of correction

Sharlene Gentry, Assistant Superintendent.

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

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This document was prepared by Residential Care Services for the Locator website.

Tag number

W368

CFR and title

§483.460(k)(1) DRUG ADMINISTRATION

Specific language from CFR

The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The facility has not had a nurse educator dedicated to training and nursing skill competency evaluations of licensed nurses. This has resulted in lack of consistent nursing skill training as well as consistent competency evaluations.

The plan correcting the specific deficiency.

1. The identified licensed nurse has been retrained on the medication administration process.
   Person(s) Responsible: Nathan Cates, RN3 Nurse Educator
   Completed by: October 8th, 2019
2. The identified licensed nurses competency was verified through a medication pass observation.
   Person(s) Responsible: Nathan Cates, RN3 Nurse Educator
   Completed by: October 15th, 2019
3. All licensed nursing staff will be retrained on Nursing Procedure "General Principles of Medication Administration."
   Person(s) Responsible: Nathan Cates, RN3 Nurse Educator
   Completed by: November 27th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. The facility has hired a nurse educator to provide clinical and practical training and education to licensed nursing staff. This includes preceptorship for new nurses, verifying nursing competency on core tasks as well as ongoing education and monitoring procedures, documentation requirements and data monitoring.
2. The nurse educator initiates regular training with licensed nurses, including medication administration. Training includes knowledge acquisition testing prior to the engagement of skill observation to verify competency.
   Person(s) Responsible: Nathan Cates, Nurse Educator
   Completed by: Initiated October 2019 and is ongoing.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

RN3's will complete medication pass observations to verify competency of licensed nurses quarterly. Immediate feedback will be provided to the licensed nurse for any identified deficit. If identified deficits are observed, additional training will be required to be completed and an additional medication pass observation will occur to verify competency. These observations will decrease in frequency, as sustainable compliance is evident but will continue to occur at least semiannually for each licensed nurse.

This document was prepared by Residential Care Services for the Locator website.

The nurse educator will facilitate ongoing nursing competency evaluations with licensed nurses. These evaluations occur at least twice a quarter and cover an array of required nursing competencies. Competencies chosen to evaluate are determined based on current facility compliance and identified deficits. Any identified deficits with a nurse during a competency evaluation will be reported to the supervisor and additional training will occur to verify competency is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Rebecca Campbell, RN4

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W407

CFR and title

§483.470(a)(1) CLIENT LIVING ENVIRONMENT

Specific language from CFR

The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents.

HPAs do not submit completed IHPs to a supervisor or a peer for review prior to implementation. This has resulted in a lack of oversight for regulatory required information and programing being present in an IHP.

The plan correcting the specific deficiency.

1. Client #3's IDT will review his CFA to verify assessments support his current placement.
   Person(s) Responsible: Ben Johnson, HPA
   Completed by: 10/11/2019
2. The HPA will update Client #3's IHP to include a justification and explanation of benefits of his current living environment.
   Person(s) Responsible: Ben Johnson, HPA
   Completed by: October 18th, 2019
3. The IDT will review all residents on Pinewood Cottage to assess and determine current housing is planned to promote the growth and development of all housed together.
   Person(s) Responsible: Ben Johnson, HPA
   Completed by: 11/15/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. IDT will review resident placement upon admission, yearly, and if a significant change of condition occurs to determine current housing is planned to promote the growth and development for all housed together. The outcome of this review and justification for current housing placement will be documented in the IHP.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency, as sustainable compliance is evident.

This document was prepared by Residential Care Services for the Locator website.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W423

CFR and title

§483.470(c)(2) STORAGE SPACE IN BEDROOMS

Specific language from CFR

The facility must provide suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Client #3's bedroom did have adequate storage space for his personal possessions. However, Client #3's IDT requested the dresser to be moved out of his bedroom to another location to assist in meeting an identified need. The IDT did not fully develop the supports necessary, including both formal and informal training, to meet Client #3's identified need.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents. This also prohibited continued HPA coaching, training and mentoring of direct care staff on regulations and how training and supports for the residents meet regulatory obligations.

The plan correcting the specific deficiency.

1. Client #3's dresser was into his own bedroom.
   Person Responsible: Ben Johnson, HPA
   Completed by: September 26th, 2019
2. A directive was sent to all employees stating that client possessions cannot be stored in another client's room. This directive also indicates that if there is a need for additional storage space for a client, to notify the ICF PAT Director who will work with the client's IDT and the Facility Administrator to provide sufficient storage space that the client has access to and does not infringe upon the rights of another client.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: 10/4/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Lakeland Village has established two additional Habilitation Plan Administrator positions to establish smaller caseloads and improved effectiveness.
   Person(s) Responsible: Tammy Haynes, DDA
   Completed by: 9/18/2019
2. Interviews with qualified HPA candidates will occur on October 9th and 10th.
   Person(s) Responsible: Lorraine McConahy, DDA; Renee Schuiteman, DDA
   Completed by: 10/10/19
3. The preferred candidate from the interview process will be properly vetted following DSHS standards and an offer will be made as applicable. Should an appropriate candidate not be revealed through these processes the DDA's will work with DSHS Talent Management to reopen the recruitment notice.
   Person(s) Responsible: Lorraine McConahy, DDA, Renee Schuiteman DDA
   Completed by: October 18th, 2019

This document was prepared by Residential Care Services for the Locator website.

4. Facility HPAs' office will be relocated to the resident living units to promote more effective and efficient monitoring of supports and training to verify the IDT is meeting the resident's identified needs as well as not violating resident rights. Seventy percent of the HPAs have been relocated to the resident living unit as of November 14th, 2019.
   Person(s) Responsible: Teri Gilden, ICF PAT Director
   Completed by: December 31st, 2019
5. HPAs have received training on the role and regulatory responsibilities of a QIDP.
   Person(s) Responsible: Westcare Management
   Completed by: October 12th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Facility HPAs will complete routine monitoring on and off the living unit of the supports provided to the residents to verify training needs are met, active treatment is continuous and aggressive, and that program implementation is occurring as expected. HPAs will provide any necessary feedback to direct care on implementing formal programs, informal objectives, and any other supports the resident needs. HPAs will schedule necessary IDT meetings to address concerns identified, facilitate any necessary revisions to the residents IHP or formal programming, as well as ensure due process is followed for any part of the resident's plan that may be restrictive.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W426

CFR and title

§483.470(d)(3) CLIENT BATHROOMS

Specific language from CFR

The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

Explain the process that lead to this deficiency.

Water temperature regulators that are located near each faucet failed. This regulators mix the appropriate amount of cold water with hot water to ensure the temperatures are within the required range. The alarm on the Med-Assist program was silenced at these locations prior to the failure of the faucet. This resulted in no alarm being raised when the regulators failed.

The plan correcting the specific deficiency.

1. The water temperature regulators at each cited location were replaced. Repeat testing after the replacement verified that the water temperature did not exceed 110 degrees Fahrenheit.
   Person(s) Responsible: JoeDavid Veliz, Facility Administrator
   Completed by: August 28th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. CSS Supervisory staff provided a clear directive to employees interfacing with the Med-Assist system that are not to be turned off in any circumstance.
   Person(s) Responsible: CSS Supervisory Staff
   Completed by: September 1st, 2019
2. Water temperatures are monitored by the Med-Assist system. Each location has an internal thermometer that reports the water temperature to Consolidated Support Services (CSS). Any identified water temperature above 110 degrees Fahrenheit will be investigated and corrected by CSS.
   Person(s) Responsible: CSS Staff
   Completed by: Ongoing.

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. Water temperatures are monitored by the Med-Assist system. Each location has an internal thermometer that reports the water temperature to Consolidated Support Services (CSS). Any identified water temperature above 110 degrees Fahrenheit will be investigated and corrected by CSS.
   Person(s) Responsible: CSS Staff
   Completed by: Ongoing.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

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This document was prepared by Residential Care Services for the Locator website.

Tag number

W436

CFR and title

§483.470(g)(2) SPACE AND EQUIPMENT

Specific language from CFR

The facility must furnish, maintain in good repair, and teach clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

IDT members did not fully understand their regulatory obligation and how each member's contribution complimented other disciplines to create a comprehensive individual program plan that met the needs of the residents. This resulted in IDT members not fully participating in IDT meetings for residents, not understanding how the content of other discipline's assessments and recommendations could affect their own, and a lack of collaboration on program development for the individual. This resulted in needs being addressed in isolation of a collaborative IDT approach.

The current span of control of HPAs (QIDP) did not allow for efficient and effective oversight and monitoring of the implementation of resident programs. This resulted in HPAs not being able to monitor staff to resident interactions in sufficient frequency and duration to verify all supports and training provided did not violate the resident's rights as well as meet the resident's individual needs. This also prohibited HPAs being able to increase their knowledge of regulatory expectations to more effectively and efficiently support residents.

HPAs do not submit completed IHPs to a supervisor or a peer for review prior to implementation. This has resulted in a lack of oversight for regulatory required information and programing being present in an IHP.

The plan correcting the specific deficiency.

1. Speech Pathologist will update Client #3's Comprehensive Communication Assessment to include, barriers to communication that are present, what services are available and what training/programs are needed to address his communication needs.
   Person Responsible: Beth Budke, Speech Pathologist
   Completion date: 10/4/2019
2. Client #3's Comprehensive Functional Assessment, (CFA), will be reviewed to verify his IHP accurately meets needs identified in the CFA. Client #3's IHP will be updated as required to include a formal communication program and accurately reflect any necessary changes.
   Responsible person: Ben Johnson, HPA
   Completed by: 10/4/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. HPAs will receive additional training on including the identified needs of the CFA in the resident's IHP. This training will include prioritization of needs as well as verifying the supports identified in the IHP are sufficient in meeting the identified needs in the CFA.
   Person(s) Responsible: Westcare Management and Staff Development
   Completed by: December 5th, 2019

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2. IDT members responsible for completing resident assessments will review current assessments to verify they accurately identify the residents' needs and meet regulatory requirements of the CFA.
   Person(s) Responsible: IDT Members
   Completed by: November 4th, 2019
3. All members of the ICF Core team have received training on the regulatory requirements of the IDT. This training included how the IDT functions together, how assessments work together to create the Comprehensive Functional Assessment for the resident, and how the HPA facilitates IDT collaboration in the development of the residents IHP.
   Person(s) Responsible: Westcare Management
   Completed by: October 9th, 2019
4. Staff Development is creating additional IDT training to for ICF Core Team members to promote further regulatory understanding of each members role in supporting the development of the residents IHP and meeting the residents identified needs.
   Person(s) Responsible: Staff Development
   Completed by: December 31st, 2019
5. HPAs will facilitate IDT meetings for each resident to review and develop an updated IHP based on the residents need and to promote continuous and aggressive active treatment.
   Person(s) Responsible: Facility HPAs
   Completed by: November 22nd, 2019
6. Westcare consultants will sit in on the IDT meetings scheduled to between November 4th thru the 22nd. Consultants will help facilitate where needed as well as provide ongoing coaching, training, and mentoring of HPAs directly after the meetings to help verify the resident needs identified are accurately captured and addressed.
   Person(s) Responsible: Westcare Management
   Completed by: Initiated on November 4th, 2019 and ongoing through December of 2019
7. HPAs will facilitate collaborative development of formal programs based on the prioritized needs that were developed during the IDT meetings.
   Person(s) Responsible: Facility HPAs
   Completed by: December 31st, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

HPAs will submit all annual IHPs to their respective supervisor for review prior to implementation. Any identified deficit will be reported back to the HPA for resolution. These reviews will continue for all new IHPs for the next year, and then will decrease in frequency, as sustainable compliance is evident.

The Quality Assurance Department will conduct a 50% review of annual IHPs for the next three (3) months. Any identified deficit will be reported to the HPA and DDA for resolution. These reviews will decrease in frequency as sustainable compliance is evident.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

This document was prepared by Residential Care Services for the Locator website.

Intermediate Care Facility: Lakeland Village
POC for SOD Date 8/29/2019 and Aspen Event ID# X9V712

Tag number

W456

CFR and title

§483.470(l)(2) INFECTION CONTROL

Specific language from CFR

The facility must implement successful corrective action in the affected problem areas.

Explain the process that lead to this deficiency.

The deficiency occurred because the monthly surveillance reports had not been completed since August 2018 and IC Procedure 1.16 had not yet been updated.
Actions were taken to implement corrective action when an ESBL E. coli organism was transmitted from one resident to another.

The facility has previously used monthly surveillance reports to review rates and trends of selected common infections. These monthly surveillance reports do not identify ESBL E. coli in routine tracking. This system of tracking infections monthly is being replaced by daily monitoring of infections, labs and antibiotic use as part of the Antibiotic Stewardship Program, using a database. The new process was implemented in August and is undergoing refinements. The new procedure/policy for Antibiotic Stewardship is in the final review process. Infection Control Procedure 1.16 SURVEILLANCE FOR HEALTHCARE ACQUIRED INFECTIONS will need to be updated to reflect the change in process.

The plan correcting the specific deficiency.

1. Instructions for heightened infection control measures were included in Client #2's Chronic Nursing Care Plan (dated 6/18/06) and Direct Care Flow Sheets.
   Person(s) Responsible: Kathy Evenson, TLRN
   Completed by: 6/18/2019
5. Staff who support Client's #2 and Client #8 received training on "Handwashing and Sanitation of surfaces and equipment to prevent the spread of infection." Upon identifying on 8/2/2019, the source of the infection as a transmission of an organism from one client to another this training was initiated.
   Person(s) Responsible: Karen Maher, RN 3 IP, Kate Olson, Pharmacist, Kathy Evenson TLRN
   Completed: 9/10/2019
2. UTI's are generally not considered a contagious illness and the risk of transmission is low, therefore the situation did not meet the criteria for an outbreak as determined by the IP.
   Responsible person: Karen Maher, RN 3 IP
   Completed 8/2/2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Nursing Procedure 9.26 ANTIBIOTIC TRACKING TOOLS (published 9/9/2019) will continue to be implemented, to include daily monitoring of infections, labs and antibiotics using the SharePoint Antibiotic Tracking database.
   Responsible person(s): Nursing supervisors, Antibiotic Stewardship Committee.
   Completed by 9/20/2019
2. The Antibiotic Stewardship Procedure/policy will be published.
   Responsible person(s): Antibiotic Stewardship Committee
   Completed by: 11/1/2019
3. The Infection Control Procedure 1.16 SURVEILLANCE FOR HEALTHCARE ACQUIRED INFECTIONS will be revised to reflect the change in process.
   Responsible person(s): Karen Maher, RN 3 IP, Antibiotic Stewardship Committee

This document was prepared by Residential Care Services for the Locator website.

Completed by: 11/1/2019

4. A UTI protocol including standardized assessment and antibiotic orders will be used for newly identified UTI's.
   Person(s) responsible: Antibiotic Stewardship Committee, Nursing supervisors.
   Completed: 11/1/2019
5. The Team Lead RN, RN 3 Supervisor or Infection Preventionist (IP) will enter information in to the SharePoint site when an antibiotic is ordered.
   Person Responsible: Karen Maher, RN 3 IP.
   Completed by: 8/5/2019
3. The new Nursing Procedure 9.26 will continue to be implemented, to include daily monitoring of infections, labs and antibiotics using the SharePoint Antibiotic Tracking database.
   Persons responsible: Rebecca Campbell, RN 4; Karen Maher, RN 3 IP, Team Lead RNs, RN 3's.
   Completed: 9/9/2019
6. A surveillance report for August of 2018 to August 2019 will be completed, and routed to the ICF PAT Director, ARNP, RN 4, and RN 3's and the Infection Control Committee. These reports will be completed monthly until the new Antibiotic Stewardship surveillance process replaces the current procedure.
   Person Responsible: Karen Maher, RN 3 IP.
   Completed by September 26th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

1. New Antibiotic Stewardship process and database will be used to monitor antibiotic use and drug-resistant organisms on a daily basis.
2. The antibiotic stewardship committee will monitor the use of the SharePoint tools and review trends/concerns.
3. The IP will provide feedback regarding entries in the SharePoint site to the nursing supervisor group on a monthly basis.
4. Nurse will continue to report two or more of the same infections on a cottage to the IP to evaluate the need for Outbreak measures.

The title of the person or persons responsible for implementing the acceptable plan of correction

Karen Maher, RN3 IP

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

[POC CONTINUED ON NEXT PAGE]

This document was prepared by Residential Care Services for the Locator website.

Tag number

W474

CFR and title

§483.480(b)(2)(iii) MEAL SERVICES

Specific language from CFR

Food must be served in a form consistent with the developmental level of the client.

Explain the process that lead to this deficiency.

In response to past citations, Lakeland Village conducted root cause analysis and implemented process improvements in isolation of more comprehensive systems analyses. This has resulted in inefficient and conflicted outcomes and impaired overall systems improvements.

Certain prepared food types are easily over modified when using certain mechanical means. This resulted in certain soft foods being modified in the kitchen prior to being delivered to the cottage being incidentally over modified.

The plan correcting the specific deficiency.

1. Food Service Workers and Cooks have received training on verifying food is altered to match the consistency identified in each client's diet order.
   Person(s) Responsible: Scott Webb, Food Service Manager
   Completed by: October 18th, 2019
2. The speech pathologist will complete an assessment to assess the appropriate texture for client #5.
   Person(s) Responsible: Beth Budke, SLP
   Completed by: October 18th, 2019
3. Client #5's IDT will review SLP recommendations for appropriate texture. The IDT will receive informed consent for any alterations in this texture for Client #5.
   Person(s) Responsible: Brittany Flores, HPA
   Completed by: October 25th, 2019

The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

1. Speech Language Pathologists and the Food Service Manager updated Diet Resource Manual 2.1 "Texture Modified Foods" to include the appropriate means for certain food types to be modified in order to meet the criteria of dysphagia mechanically altered textures.
   Person(s) Responsible: Speech Language Pathologists and Food Service Manager
   Completed by: October 25th, 2019
2. Speech Language Pathologists developed job aids detailing appropriate means and methods of altering diet textures to dysphagia mechanically altered as well as trained cottage staff.
   Person(s) Responsible: Speech Language Pathologists
   Completed by: October 25th, 2019
5. LV Form 17-242A, Informed Consent Medical and Adaptive Equipment has been modified for the IDT's to utilize for modified diet textures, which includes a justification, risk versus benefit analysis, and guardian signature.
   Person responsible: Tammy Treat Haynes DDA
   Completed by: September 16th, 2019

The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with regulatory requirements.

Speech Language Pathologists will conduct regular meal observations, including preparation, to verify foods are altered to the appropriate textures. Speech Language Pathologists will provide direct feedback for any identified deficit. Any identified deficit will also be reported to the employee's supervisor for resolution.

This document was prepared by Residential Care Services for the Locator website.

The title of the person or persons responsible for implementing the acceptable plan of correction

Teri Gilden, ICF PAT Director

Dates when the corrective action will be completed.

Lakeland Village will complete the corrective actions by January 3rd, 2020.

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